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Lead Poisoning—An Eradicable Disease

Why Children Are In Jail

Methods for Disadvantaged Preschoolers

A Preschool for Disturbed Children

VOLUME 17 • NUMBER 1 • JANUARY–FEBRUARY 1970

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

29 June '71

etting to know one another, this eschool child and her teacher ter into a wordless exchange at can be a major step in build-g a path of communication be-een them. The teacher's goal in sponding to such nonverbal orts at communication is to engthen the child's capacities r learning and using language. ther steps to helping disadvant-ed children overcome develop-ental deficits are described in e article beginning on page 15.

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JANE S. LIN-FU

In the history of modern medicine, few chil
hood diseases occupy a position as unique
lead poisoning. It is a preventable disea
The etiology, pathogenesis, epidemiology, a
symptomatology have all been well defined. Metho
for screening, diagnosis, and treatment have lo
been available. In the past three decades, concert
efforts to conquer infectious diseases have resulted
the development of vaccines for such viral diseases
polio and measles, the discovery of many antibioti
for bacterial and other infections, and the systema
application of these therapeutic agents, but little h
been done to eradicate lead poisoning. Yet this ma
made disease exists in epidemic proportions in ma
cities.

While mortality and morbidity associated wi
such diseases as polio, tuberculosis, meningitis, a
pneumonia have declined sharply, lead poisoning h
continued to take a high toll among children. Silent
almost unnoticed, it causes the needless death
many children and leaves many more with ment
retardation, cerebral palsy, convulsive seizur
blindness, learning defects, behavior disorders, k
ney diseases, and other handicaps.

Lead poisoning, or plumbism, is largely an occu
tional disease in adults. But in children it is alm
invariably caused by repeated ingestion of chips a
flakes of lead-containing paint and plaster from t
walls, windowsills, and woodwork of dilapidated p
World War II houses. Because of its roots in dila
dated housing in old urban neighborhoods, it has

CHILDHOOD LEAD POISONING . . .

an eradicable disease

gh incidence only among children living in city
ums. In these areas, accessibility to flaking and peel-
g lead paint and broken plaster, lack of knowledge
nong parents that ingestion of lead paint is danger-
s and even lethal, frequent inadequate parental
pervision of young children, and a high incidence
pica (a perverted appetite for nonfood items such
dirt, paper, paint, and plaster) all set the stage for
ad poisoning.

Children between 1 and 6 years old are the main
ctims, and those between 1 and 3 years of age com-
ise 85 to 90 percent of the cases. Boys and girls are
fected equally. A high incidence is reported among
egroes and Puerto Ricans, probably because such a
rge proportion of these ethnic groups live in "lead
lts." Lead poisoning occurs the year round, but lead
cephalopathy (brain injury caused by lead), a very
rious complication, is much more frequent during
e summer. Some cases occur in winter when leaded
ttery casings are burned for fuel and the fumes are
haled or there is prolonged contact with the ashes.

Nobody knows how many children in the United
ates are exposed to this health hazard and how
ny are actually poisoned, for many cases of lead
isoning are never diagnosed. But since the problem
closely related to poor housing conditions, an edu-
ted guess may be made on the basis of the number
old deteriorating houses in the United States and
e known prevalence rate of lead poisoning among
ildren living in such houses. According to the 1960
ousing Census, 30.6 million of the occupied housing units in the United States were built in or before 1939, before the use of lead-based paint was outlawed in most States. Of these units, 5.6 million were classified as deteriorating and 1.8 million as dilapidated.

Although since the 1940's lead pigment has been replaced by titanium in interior paints, recent surveys in Baltimore, Philadelphia, and Minneapolis revealed that from 40 to over 80 percent of houses in selected slum areas still contain dangerous quantities of flaking lead paint that was applied many years ago. Surveys have indicated that among children living in such dwellings from 10 to 25 percent of those between 1 and 6 years of age have absorbed potentially dangerous quantities of lead, although clinical symptoms of lead poisoning have been present in only 2 to 5 percent of the children.[1] It is thus apparent that childhood lead poisoning is disturbingly prevalent in well delineated areas in many old cities.

Equally disturbing are the mortality and morbidity associated with this disease. Until the advent of chelating agents—therapeutic agents that bind the lead ions and remove them from the body—about two-thirds of the children with lead encephalopathy died. Even with the use of chelating agents, first BAL (British anti-lewisite) and later EDTA (ethylenediaminetetracetate), the fatality rate remained a shocking 30 percent for many years. More recently, with the use of BAL and EDTA in combination and other supportive therapy, the fatality rate has been reduced to less than 5 percent.

But the reduction of the fatality rate in treated

All the ingredients for an incipient case of lead poisoning are present in this picture—old peeling plaster containing lead-based paint within reach of a toddler, who, like most children of her age, is likely to pick up and eat anything.

cases is neither evidence of adequate control of the disease nor a cause for complacency, because many of the survivors are left severely handicapped. A follow-up study of 425 children in Chicago who were treated for lead poisoning revealed that 39 percent had some kind of neurological sequelae. Among the 59 children in this group who before treatment presented symptoms of lead encephalopathy, 82 percent were left with handicaps: 54 percent had recurrent seizures, 38 percent were mentally retarded, 13 percent had cerebral palsy, and 6 percent had optic atrophy. Some had multiple handicaps.[2]

In Queensland, Australia, extensive epidemiological studies have demonstrated a high incidence of chronic kidney disease among patients who had lead poisoning in childhood 10 to 40 years ago. Half of these patients with kidney damage also suffered from gouty arthritis and many had severe high blood pressure, mental impairment, and various kinds of psychiatric disorders.[3]

Thus far studies on the effect of increased lead exposure have focused largely on the sequelae of overt poisoning. Little is known and little has been done to determine whether or not damage to the body occurs at a low level of exposure. Although clinical symptoms of lead poisoning often do not appear until the blood lead level is .06 mg/100 gm. of blood or higher, it is generally agreed that the normal blood lead level should not exceed .04 mg/100 gm. Recently it has been suggested that chronic debilitation and damage, which may not be recognized for many years, may result from an intake of lead far below what has been assumed to be dangerous, and that lead may be harmful to the body even in the absence of clinical symptoms.

Lack of awareness

The foregoing facts about lead poisoning pos a compelling question: How can a disease so prevalent and with such serious results escape attention o both the public at large and the Nation's health workers? In looking for an answer, one must first realize that lead poisoning in children is an illness rooted in social, economic, educational, psychological cultural, medical, and even political factors. A direct result of a child's environment, it is prevalent onl among children whose families are least able to improve their living conditions and who are not generally informed. The well-informed segments of th population are seldom affected.

Moreover, the answer is that many health worker who work among the poor are not aware that lea poisoning in children is still a problem. They apparently think that the mandatory use of lead-free pain for toys, furniture, and interiors of dwellings durin the past quarter century has eliminated the problem Furthermore, childhood lead poisoning is a diseas that health workers may not recognize, even thoug it exists in epidemic proportions, because it has n distinctive clinical features. The symptoms of childhood lead poisoning are nonspecific. Anemia, listlessness, excessive irritability, loss of appetite, abdominal pain, constipation—signs and symptoms tha appear before obvious evidence of encephalopathy such as vomiting and convulsions—can all be misinterpreted as indications of some other illness. Becaus children who suffer from lead poisoning come fro the slums, their anemia may be considered to be th result of inadequate nutrition; their listlessness an excessive irritability, to be the results of a patholog cal home environment; their abdominal pain an vomiting, to be symptoms of indigestion or gastroenteritis. Even convulsions may be regarded a signs of epilepsy rather than as evidence of lea encephalopathy.

Routine physical examination, blood count, an urinalysis will not provide an unsuspecting healt worker with the correct diagnosis. Unless the worker inquires specifically whether the child has eaten chips of paint or plaster and draws a blood specimen for lead determination, he is likely to miss the diagnosis altogether and treat the child for something else, only to be confronted later with the same patient, who may then exhibit signs of brain injury, which may already be irreversible. In cities with a high incidence of lead poisoning, certain hospitals serving children from known "lead belts" report few or no cases of the disease.

Inadequate housing codes

In addition to poor housing conditions and a general lack of awareness of the problem, other elements contribute to the persistence of lead poisoning. Many cities in which lead poisoning is a public health problem do not have health or housing codes adequate to protect tenants from exposure to lead paint. Even in cities with codes specifically prohibiting lead paint in the interior of dwellings, enforcement of such codes is generally far from satisfactory. The currently available methods of paint removal are expensive and many landlords are not willing to undertake this expense. In cities with large slum areas and insufficient housing for people of low income, city officials sometimes hesitate to enforce the housing codes, reasoning that too rigorous enforcement would compel the landlords to abandon their slum buildings, thereby creating more problems for the city. Even when city officials are interested in enforcing codes, they frequently do not have enough inspectors and sanitarians to carry out the necessary procedures for enforcement—inspection of houses, collection of paint specimens, testing for lead content, and reinspection.

Another reason housing codes are not effective is that enforcement relies primarily on the criminal process, usually in the form of misdemeanor prosecution in the lower criminal courts. Criminal prosecution in such cases is fraught with many procedural and conceptual difficulties. First, summonses are often improperly served, being sent by mail rather than delivered by hand. Even when a landlord has been properly served with a criminal summons, he may fail to appear in court and thus force a postponement. Because a criminal court cannot proceed with a case until the defendant appears in court, housing cases often remain pending for months or even years. When the landlords do appear in court, adjournments and delays are frequent. Furthermore, proving the guilt of the offender beyond a reasonable doubt may be a long and complicated procedure in a lead poisoning case.[4]

When a landlord is found guilty, there is still the so-called "conceptual hurdle"—the reluctance of criminal courts to recognize a housing violation as a true "crime." A distinction is often made between the so-called "true crime" such as murder, assault, and robbery, and the "social welfare offenses" or crimes of omission, which consist of failure to meet health and safety standards. Penalties imposed for the latter offenses are generally minimal and inconsequential. In New York City, for example, while the city's statutes allow the imposition of fines ranging up to $1,000 per violation and provide for jail sentences of up to 1 year for repeated offenders against the housing code, in practice, jail sentences have practically never been imposed. In 1965 the average fine per case was less than $14; the average fine per violation was about 50 cents. Of the cases that did draw fines, many involved violations that had been uncorrected for years. Such inconsequential penalties convince many landlords that it is cheaper to pay the fine than to do the repair.[4]

Failure to get rid of lead paint in a house where a child is known to have developed lead poisoning usually means that a treated child returns to the same hazardous environment to be exposed to another episode of poisoning. The recurrence rate is high in lead poisoning. Among survivors of acute lead encephalopathy who are reexposed to an environment that contains lead paint, the incidence of severe permanent brain damage is almost 100 percent. *Thus early casefinding and treatment programs are virtually meaningless when treated children are returned to their old environment.* Even when a lead-free home is found for a treated child, this merely solves the problem for that particular child; it presents no solution to the problem of lead poisoning in general. If the lead paint in the house is not removed, the lethal heritage will soon pass on to other families with children, and lead poisoning among children multiplies.

Steps to eradication

While the obstacles to the eradication of lead poisoning are tremendous, they are not insurmountable. Slum clearance combined with provision of adequate housing for the poor is the most effective means of eliminating lead poisoning. But even before this measure is undertaken on the scale required, lead poisoning may be reduced through education, early detection, treatment, and follow-up programs that

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include removal of lead from houses wherever it is found. A few cities have demonstrated the value of such methods.

In Chicago, for example, there is a massive screening program for lead poisoning operated through the coordinated effort of local officials, health workers, and the community.

In the summer of 1965 a Citizens Committee to End Lead Poisoning was founded after the discovery of several cases of lead poisoning in the East Garfield Park District. With the help of the American Friends Service Committee, the Chicago Board of Health, and the Medical Committee for Human Rights, an educational and casefinding program was launched. A group of dedicated teenagers carried on a door-to-door campaign in the area, collecting urine specimens from children to be tested for lead poisoning.

In December of the same year the Chicago Board of Health announced plans for a large-scale screening program, and by the next September, 30,000 urine specimens had been tested. In October 1966 the Board of Health began an extensive casefinding program based on blood lead determination by atomic absorption spectroscopy—a screening method far superior to the urine test used earlier. The program has been conducted through the OEO-sponsored Chicago Committee for Urban Opportunity and supported in part by the Children's Bureau and State funds. Community representatives, working out of Urban Progress Centers, go from door to door distributing leaflets and alerting parents to the hazards and symptoms of lead poisoning. They also arrange for all children in the family between 9 months and 5 years of age to have a blood lead test made in the Urban Progress Center by a Board of Health physician. The Lead Poisoning Clinic, headed by Dr. Henrietta K. Sachs, was established for the diagnosis and treatment of children found in the screening program to have elevated blood lead levels.

By October 31, 1969, over 120,000 children had been tested, and over 1,500 children had been treated. As a result of this intensive program, the incidenc of elevated blood lead levels among children fro the same areas declined from 8.5 percent in 1967 t 3.8 percent in 1968. Along with a rise in the numbe of cases of the disease that were detected came decline in the fatality rate. In 1963, the first yea the disease was made reportable, 203 cases of lea poisoning were reported in Chicago and the fatalit rate was 2.9 percent. In 1968 the number of reporte cases rose to 702 while the fatality rate dropped t 1.3 percent. But because many children were returne to the homes in which they had developed lea poisoning, some recurrence among treated childre was reported.

Similar figures have been reported from New Yor City where physicians from all medical agencies i the city are encouraged to send blood specimens o all suspected cases of lead poisoning to the city healt department laboratory for prompt and accurate bloo lead analysis. In 1954, New York City reported 8 cases of lead poisoning and a fatality rate of 15 percent: in 1968, the fatality rate was less than 1 percen in the 725 cases reported. The city health departmen is currently working with the lead poisoning screening programs of the Montefiore Hospital and o the federally supported comprehensive health car projects for children and youth at the Albert Einstein College of Medicine, the Jewish Hospital an Medical Center of Brooklyn, the Brookdale Hospita Center in Brooklyn, and Roosevelt Hospital. Becaus approximately 75 percent of the children with lea poisoning reported in New York City are from families receiving public assistance, plans are underwa to mail with public assistance checks a leaflet on lea poisoning written in both English and Spanish. I has also been proposed that the leaflet be mailed wit birth certificates so parents will become aware of th problem before their children reach the age of risk.

In Philadelphia, lead poisoning was made a reportable disease in 1950. But from 1950 to 1960 onl 278 cases were reported; these cases involved 5 deaths. In 1961 the Electric Storage Battery Co. began to provide free blood lead determinations fo suspected cases. As a result, 109 cases and seve deaths were reported during 1961.

In 1966 the Philadelphia City Council adopted a ordinance amending the Health Code and the Boar of Health issued regulations regarding the labeling application, and removal of lead paint. In reporte cases in which lead paint in the interior of dwelling proves to be the source of poisoning, the Board o Health requires all loose paint to be removed whe

er found and all intact lead paint accessible to chil-
en to be removed down to the bare surface of the
ll. Premises may not be repainted until they are
proved on reinspection.

Since the ordinance and regulations became effec-
e, approximately 400 properties have been made
fe in this way. During the same period—1967 to
68—there were 176 cases of lead poisoning and two
aths reported.

In 1968, a urine screening program for lead poison-
g among children 1 to 3 years of age was initiated
the child health conferences of three district
alth centers in Philadelphia's high-risk areas.

Baltimore was one of the first cities to recog-
ze lead poisoning in children as a public health
oblem. For more than 30 years, it has demonstrated
interest in this problem through continuous detec-
on and prevention programs that include enforce-
ent of health and housing codes, epidemiological
rveys, and intensive educational campaigns. Aided
the Property Owners' Association, the health de-
rtment has obtained good cooperation from
ndlords.

Unlike other cities that have detected increasing
mbers of cases, in recent years, as awareness of
e disease has increased, Baltimore has reported a
eady decline since 1958 when 133 cases and 10 deaths
ere reported. In 1968 only 13 cases and no deaths
ere reported. Only one death was reported for each
the years 1964, 1966, and 1967, and none in 1965.
hese figures probably do not represent the real in-
dence and fatality rate of lead poisoning in Balti-
ore, and should be interpreted with caution. It may
ot be entirely unreasonable, however, to speculate
at the continuous existence of the various programs
r many years, along with paint removal from many
wellings, has yielded encouraging results.

oluntary action

Two years ago, the Urban League of Rochester,
.Y., persuaded 22 youths from its Project Uplift
outh Incentives Program to assist the Rochester
ommittee for Scientific Information (RCSI) in its
udy of lead poisoning. The young people collected
aint samples from slum homes and turned them
ver to RCSI for analysis. Since then Project Uplift
as assigned smaller groups of youths to work with
e Rochester Neighborhood Health Center and with
octors from the University of Rochester's Strong
emorial Hospital Department of Pediatrics. Last
ummer the young people and the Rochester Neighborhood Health Center distributed material explaining the campaign to all families registered with the health center. Teams, of two teenagers each, visited the homes to find out whether the children had eaten paint and to collect paint samples. If a paint sample showed a dangerous content of lead, the teenagers collected urine samples from the young children living in those dwellings for testing for lead poisoning. Subsequently, those children whose urine showed positive results were examined thoroughly. Nearly 7 percent of the children tested thus far have been found to have dangerous levels of lead in their systems.

In New York City the New York Scientists' Committee for Public Information has called the public's attention to lead poisoning by sponsoring meetings both for the population at risk and for health and community workers.

In Minneapolis the University of Minnesota Bio-

A member of Project Uplift, a teenage volunteer organization sponsored by the Urban League of Rochester, N.Y., collects a sample of peeling plaster from an innercity dwelling for analysis to determine whether the paint contains lead.

medical Student Committee for Social Responsibility and the Minnesota Committee for Environmental Information have sponsored a program to determine the prevalence of lead poisoning in one area of the city. Two University of Minnesota research assistants conducted a survey in early 1969 and found that 40 percent of the houses they examined had chipping interior paint with dangerous lead content. On the basis of this finding, a screening program was begun for children in the high-risk areas. In the summer of 1969 the Minneapolis City Council passed an ordinance prohibiting the use of lead paint in dwellings.

Many comprehensive health care projects for children sponsored by the Children's Bureau have set up programs to control lead poisoning. Among these are projects at the Hill Health Center in New Haven, the Children's Hospital of the District of Columbia, and the ones in New York City already mentioned.

The Johns Hopkins University School of Medicine has received a grant from the Children's Bureau for an urgently needed study of tests used in screening children for lead poisoning. The goal is to develop a simple, quick method of determining the amount of lead in human blood for use in large-scale screening programs. At present blood lead determination, in which a physician or skilled technician must puncture the vein to draw enough blood for analysis, is the only reliable test available. The successful use of this test with more than 120,000 children in Chicago is evidence of its feasibility as a large-scale method of screening for lead poisoning. However, scientists are seeking a quicker, but equally reliable, method that will require only the small amount of blood obtained from a finger prick.

The two currently used urine tests are far from satisfactory; the coproporphyrin test is often negative in lead poisoning and positive in other diseases, while the ALA (delta aminolevulinic acid) test is found to correlate poorly with blood lead levels. Moreover, it is difficult to collect urine from children from 1 to 3 years of age, the age group with the highest incidence of lead poisoning. Determination of the level of lead in hair has also been suggested as another screening test. Because the usefulness of this test has been questioned, further evaluation of it is needed.

In 1969 the Lead Industry Association published a booklet entitled "Facts About Lead and Pediatrics," presenting seven steps to the prevention of lead poisoning. The booklet is being distributed to physicians, public health authorities, social workers, city officials, and others who can help achieve pr vention and control of the disease in children.

The recent upsurge of interest in childhood lea poisoning among Federal and local agencies, cit zens' groups and government officials, health an community workers, and private and public institutions encourages the hope for an eventual end of thi preventable manmade disease. But much mor needs to be done.

Steps ahead

The ideal solution to childhood lead poisoning i slum clearance and urban renewal with the provisio of adequate housing for families of low incomes. Bu this goal cannot be achieved quickly. Meanwhil control and prevention must depend on other mean such as:

1. Public education through all channels and al media of communication to point out the danger of paint eating, to acquaint the public with the symptoms of lead poisoning, and to urge parents to see help whenever lead poisoning is suspected, even i the absence of symptoms. Many parents who ar aware that their children eat paint do not know tha this is dangerous. Among women who themselve eat clay or starch—a common practice in certai cultural groups—a child's paint eating may no receive attention.

2. Education of physicians, nurses, social worker and all other health workers on the prevalence o lead poisoning among children so that they will always have an index of suspicion. Health worker should routinely inquire about pica and paint ingestion in all children 1 to 6 years old, particularl those from high-risk neighborhoods, and shoul look for lead poisoning even before overt symptom appear.

3. Mass screening programs in "lead belts" for al children between 1 and 6 years of age, using bloo lead determination, the only reliable screening test

4. Immediate referral of children found to hav elevated blood lead levels to a medical center for diagnosis and treatment if necessary; prevention of treated child's reexposure to lead in the home; an followup and retesting of all treated children wh continue to be exposed. The prevention of reexposures means that health workers must work closel with housing authorities to see that lead paint is re

oved from every dwelling where poisoning has :curred.

5. The establishment of effective health and hous- ıg codes pertaining to lead and lead poisoning and ıe diligent enforcement of these codes. Where codes :e not enforced, court action may be necessary. In ew York City, for example, where the health de- ırtment is said rarely to invoke a law allowing it to quire landlords to correct lead hazards, a neighbor- ood health center is seeking court orders for land- rds to repair as common law nuisances dwellings here children have suffered lead poisoning. Other easures that have been advocated are withholding nts to make the necessary repairs or fining land- rds for each day the violations remain uncorrected.[5]

6. A concerted effort by research institutions to evelop a simple, practical, and relatively inexpen- ve method for paint removal. The expense of cur- ntly available methods to make paint inaccessible children—either by paint removal through burn- ıg, scraping, and sanding, or by covering the old ıint with plasterboard or fiberglass—is an impor- nt deterrent to correction by landlords.

Research is also urgently needed to accomplish the llowing objectives:

- Development of a simple portable device for lead etection to make it possible systematically to iden- fy houses containing lead paint. At present detec- on of lead paint in houses involves collection of ıint samples and chemical analysis of such samples.
- Evaluation of available screening tests for lead oisoning and development of a reliable, simple, in- pensive method to determine blood lead level.
- Prospective studies of children with elevated ood lead levels who are "asymptomatic," to deter- ine the subtle effects of lead that do not become im- ediately apparent.
- A uniform reporting system for all screening rograms to facilitiate the collection of pertinent data, exchange of information, and comparison of results.
- Improved methods of treatment to reduce not only the number of deaths from lead poisoning, but also the residual effects in survivors.
- Increased knowledge about the causes and cures of pica to reduce the incidence of lead ingestion.

THE ESTIMATED COST of treatment and institutionalization to the age of 60 of a person who incurs severe permanent brain damage from lead poisoning in childhood is about $222,000. Complete removal of old lead paint from an average rowhouse with 10 windows, two doors, and baseboards would cost $250 to $300; replacement of window and door units and baseboards in such a house would cost $600 to $1,200.[6] These figures show only the difference in dollar costs between preventing lead poisoning through paint removal and permitting severe brain damage to occur in children. They do not take into consideration the suffering and heartache of affected families or the loss of useful manpower to the Nation.

Until society recognizes that permitting children to be killed and crippled by lead through paint ingestion is a crime not very different from permitting massacre and maiming of children by the use of lead bullets, this needless manmade disease will continue to victimize children.

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. . . cities have shown a unique and enduring propensity to create health problems and then elect to treat the symptoms rather than deal with the causes.

Alonzo S. Yerby, M.D., at the 1964 annual meeting of the American Public Health Association.

a preschool workshop for EMOTIONALLY DISTURBED CHILDREN

JUDITH BLOCH

A multidisciplinary team of staff members and volunteers, working together in a voluntary nursery-kindergarten school for emotionally disturbed and neurologically impaired children in Nassau County, N.Y., is demonstrating the value of meeting the needs of functionally retarded children early in their lives before their condition becomes aggravated or fixed. The form of the program is educational; the intent, therapeutic; the method is to provide the child with experiences that he can deal with successfully. The objective, in most instances, is to improve the child's level of functioning so that he can become able to attend special education classes in a public school and profit from the experience. In some instances, however, the impairment is so severe that the primary objective is to help the child learn enough self-care to be able to avoid institutionalization.

The kindergarten-nursery school is operated on the theory that certain kinds of experience and environment provided a child at a particular point in his development can influence behavior in a way that may not be possible at a later date.

The school, called the Preschoolers' Workshop, was chartered by the New York State Board of Regents in 1967 as a nonsectarian nursery school. It had begun operations a year earlier with a class of five children referred by community hospitals and child guidance clinics. In the fall of 1969, it had a total of 22 children aged 2½ to 7 enrolled in three separate classes—a kindergarten and two nursery school classes. Its experience thus far seems to support the theory that just as there is a critical time for growth and development in the early years of every child's life, so there may well be a critical time for therapeutic intervention in the early years of an emotionally disturbed child's life. The best time for therapeutic intervention seems to be as close to the onset of the dysfunction as possible, while the child is still at an age that falls within the normal developmental timetable. For example, efforts to teach a mute child speech seem to be more effective with a 3-year-old child, who is still within the broad age range for acquiring speech, than with a similar 5-year-old child, who has already made an adjustment to muteness and has passed the developmental stage for acquiring speech.

This point of view is based on an awareness of the significance of the early years of childhood in human development. The work of Ribble,[1] Spitz,[2] and Anna Freud,[3, 4] leads to conclusions that early childhood experiences are crucial and that young children are particularly influenced by their environment. Erikson [5] has suggested that if the sequence of budding impulses in the infant or child is disturbed at critical stages of development, the child will be impaired.

Kanner and Eisenberg [6] have noted that the schizophrenic child who has not developed speech by the age of 6 is not ever likely to develop speech. As a result of his research with young children, Bloom has reasoned that a child's environment would have its greatest effect on a characteristic during its period of most rapid development. He has found "a negatively accelerated curve of development" that reaches its midpoint before age 5. Bettelheim [8] has suggested that children may be especially vulnerable to trauma at certain stages of development. Mothers as well as behavioral scientists, know that children seem to have their own built-in timetables for growth.

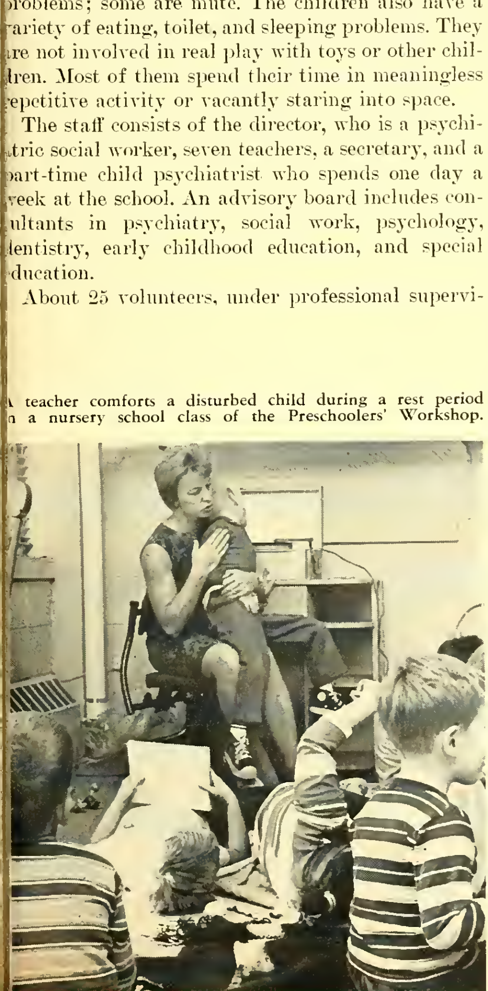
A child is admitted to the Preschoolers' Workshop on the basis of his level of functioning, available penings in a given group, and evaluations by a sychologist and a physician—either a neurologist r a psychiatrist. Classes are formed on the theory hat heterogeneity fosters learning and development etter than homogeneity. Thus, each of the three groups is made up of children having many different inds of problems—including diagnosed psychosis, nfantile autism, childhood schizophrenia, and neuro- ogical impairment. The prognoses for all the chil- lren are grim because the children are also function- lly retarded, but their functioning in certain areas uggests that many have potential for development.

A striking quality in some of the children is their nability to relate to their surroundings, ranging rom fleeting to continuous unawareness of people nd objects. All the children have severe language roblems; some are mute. The children also have a ariety of eating, toilet, and sleeping problems. They re not involved in real play with toys or other chil- lren. Most of them spend their time in meaningless epetitive activity or vacantly staring into space.

The staff consists of the director, who is a psychi- tric social worker, seven teachers, a secretary, and a art-time child psychiatrist who spends one day a eek at the school. An advisory board includes con- ultants in psychiatry, social work, psychology, entistry, early childhood education, and special ducation.

About 25 volunteers, under professional supervision, help in the program. Some work directly with the children as teacher aides and others work as fund raisers and liaison workers with community organizations that support the school financially.

teacher comforts a disturbed child during a rest period n a nursery school class of the Preschoolers' Workshop.



During the regular school months, the kindergarten class meets for 5 hours a day and the two nursery classes meet for 3 hours in the morning. The children are transported to the Preschoolers' Workshop building in Garden City, N.Y., on buses from their local school districts. The school receives financial support from the State education department, the county's family court, Investors Overseas Securities and George Loft Foundations, private contributors, and the Ethical Humanist Society, which provides the building at nominal cost. Parents are charged according to ability to pay.

An individual plan of self-care is formulated for each child within a loosely structured classroom situation. The staff primarily relies on a description of the child's functional behavior rather than on the psychiatric label in preparing each plan. Toilet training, dressing, self-feeding, and appropriate use of materials are basic goals. To help the child develop a sense of self, teachers frequently discuss with the child his perceptions of who he is, where he is, and what he is doing. This self-realization, in turn, is used to help the child increase his comprehension. When a child does not speak, teachers encourage forms of nonverbal expression. The staff members and volunteers work together to provide activities that improve communication, attention, and concentration, develop speech and language, give a child a sense of success, and help him compensate for his deficits.

From the beginning, the Preschoolers' Workshop has involved parents in its program. As Lorna and J. K. Wing [9] have pointed out, faulty mothering is not necessarily responsible for the disturbed child's condition. However, since seriously disturbed children have little capacity to ward off or cope with malignant influences in their environment, they may be even more vulnerable to mismanagement than other children. At the Preschoolers' Workshop, stress is put on giving parents an understanding of the school's philosophy as it specifically applies to the program formulated for dealing with their child both at school and at home.

A discussion group for mothers meets with the director twice each month. Through open discussion the mothers' attention is focused on possible solutions to the overwhelming family and personal problems posed by the children as well as on practical ways of managing them at home. Follow through at

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home in reinforcing behavior learned by the child in school is an essential part of the child's program and requires continuous coordination between home and school. Such coordination is partly achieved through the mothers' group and partly by individual conferences between the director and the mother or both parents, as needed. An evaluation conference for assessing the child's present status, his gains, and future goals for him may be scheduled with the psychiatrist, teacher, director, and parents. In addition, parents have one formal conference with their child's teacher each semester. The teacher is, of course, always available to parents for informal conferences.

One boy's progress

The following case story illustrates how early intervention seems to have had great impact in the life of one child, David.

David came to the Preschoolers' Workshop when he was 3½ years old. A big, strong boy for his age, he had not learned to use language, although he was able to vocalize and make occasional unclear sounds. He was the youngest of three boys of well-to-do parents, both of whom were college graduates.

A psychiatrist who saw David just before he was admitted to the school observed, "David responded to no oral command; only physical restraint would remove him from danger. He said no recognizable words, but babbled quite a bit. His motor behavior was awkward, his movements clumsy. He enjoyed rotary and antigravity play, became excited, and demanded more. He had a brief tantrum when this was denied."

The staff of a medical center diagnosed David as "an organic schizophrenic child with secondary autism and at least a 50-percent deficit in intellectual functioning."

David's mother said that David spent most of his time at home alone in his room by choice. There he would rock himself endlessly or watch the record player turn.

When David entered the school, he used the record player to shut out staff members and play equipment in the classroom. He did not respond to—or even seem aware of—either the staff members or other children. His interest in toys and play materials was fleeting; he often puts toys in his mouth, but he did not play with them. His understanding seemed very limited because he did not follow instructions. With the introduction of each new classroom routine, he would cry and become extremely agitated. Sometimes he had severe temper tantrums, throwing himself backward on the hard floor, banging his head and screaming. He was not toilet trained, and he frantically resisted all attempts to take him to the bathroom.

The nursery school team gave David time to overcome his initial panic and to accept the setting and staff members as essentially protective. Then the record player was removed. It took all the skill of the entire team to teach David to play. He was offered toys with "built-in success," toys that were neither frightening nor too difficult for him to master. A soap bubble pipe, water toys, and balloons tempted him only briefly. Several windup mechanical toys interested him, and David began to play with them in an appropriate way.

Since David was particularly fond of sweets, cookies were always available in the early part of his treatment program to console him when he was sad or to induce him to try a new experience, such as sitting next to the teacher and watching her put pegs in holes or work a puzzle.

After about 6 months, David's attitude toward the school changed. He came eagerly, and some days he was reluctant to go home. This was the first indication that he was comfortable in school. At this point, staff members used a great deal of nonverbal communication as they tried to make themselves important to David by understanding and anticipating his needs and interests. They carefully attempted to nurture his comprehension, speaking in short direct sentences and using props to help him understand. For example, a teacher would point to pegs in her hands as she said, "I'm playing with pegs." The invitation to David to join in the game was implicit in her voice. She often gave a simple, running commentary to describe his activity: "You are eating a cookie."

When David chose to stare blankly into space, a teacher would bring a toy to him and sit quietly be-

Two principles of the Preschoolers' Workshop are demonstrated in this picture: Center, providing an activity that encourages concentration; background, using physical contact to help children focus their attention on a purposeful activity.

side him, playing with it herself. This was seldom enough to entice him to look at the toy, however. It was then that the team began the game of intrusion. A teacher or volunteer would put her hands on David's hand to push a peg into a hole. Staff members engaged in a great deal of nonverbal communication and play with David, treating him as they would a very young child. He particularly enjoyed the game of peek-a-boo in all its variations.

As David's ability to understand increased, he sought the undivided attention of the teacher more often. When he began to want such things as food and toys, she insisted that he make sounds. She repeatedly named things for him—food, toys, parts of the body—both in words and in song during play periods. The staff members always responded to David's verbalization, in a sense making it "pay to talk." For example, he had to say the word "cookie" to get one. He seemed to be experiencing some of the pleasure and power from language that sometimes characterize the 2-year-old's first attempts to speak.

As David's vocabulary broadened and developed, he became a demanding, tyrannical, willful, and often noncompliant taskmaster—but not in the old unrelated manner. He grabbed toys from the other children. He responded to every request with an emphatic "no." This was a trying time. David was determined to decide not only what he would do but also what the teacher should do; for several months he made constant demands on her. Team members tried to sort out what he needed and come through for him with an appropriate response—comfort when he was frightened or quiet companionship when he was overexcited. David still needed to be able to control his own behavior and to be free to make real choices. However, he was not allowed to control the teacher's behavior if this upset either the teacher or interfered with the functioning of the class.

David gradually moved out of this totally negative period. For some time, however, he responded to most suggestions by at first saying "no," and then later becoming more obliging and cooperative.

The record player, which had been a source of great distress to him, continued to present problems. David was not able to control himself when it was played. He would scream "no," and try to make the teacher turn it off. If unsuccessful, he would panic and run from the room. Slowly he developed the ability to stay in the room briefly when a record was playing.

David ended his second year at the workshop as a very different child. He was loving and affectionate; he enjoyed being held, tickled, and kissed. Having passed through his period of willful negativism, he was cheerful and happy most of the time. He talked in short phrases. He used language to communicate, to ask for something, to indicate feelings. He had acquired a vocabulary that he used spontaneously. He would listen to and follow directions; his comprehension was apparent in his cooperation.

Intrusion as an approach

Intrusion is a major technique used with withdrawn children at the Preschoolers' Workshop. For example, when attempts to interest David in activity were not effective, the teachers physically intruded on him in such a way that he could not shut them out. They made contacts with him by touching, holding, or pushing him. In effect, directions or suggestions were accompanied by a physical concomitant. David was invited to join in a circle game by a teacher who took his hand and led him to the circle. If David did not respond to the teacher's voice, she might gently turn his cheek so that he could not avoid her direct gaze.

He was eager to play peek-a-boo. The teacher or volunteer would cover his eyes with his own hand, alternately spreading the fingers wide and holding them together, or partially hide his face behind a book, balloon, or her hand. He always responded to this peek-a-boo form of intrusion with enthusiasm.

In the beginning, when teachers and volunteers frequently intruded on David, he would become angry and resistive. Gradually, as he learned to play for increasing periods of time, such intrusions became less necessary. He eventually learned to look at, touch, and play appropriately with almost all the material in the classroom.

The use of intrusions by the staff is similar to the approach Austin DesLauriers[10] developed in his work with adolescents with schizophrenia. In the Workshop, the intruding adult always behaves as a mature, responsible adult; DesLauriers, in contrast, used any dramatic approach—however unorthodox—that would arrest the attention of the patient.

At the Preschoolers' Workshop, the nature of the intrusion itself is designed for the child. For David, a game of peek-a-boo was the major instrument of intervention. For another child, Billy, physical contact was used in efforts to increase the child's perception of his surroundings.

When he entered the nursery school, Billy seemed to be in a trance most of the time. To help him, the teacher would grasp his hand firmly and say, "I am holding your hand and these are your fingers." She would place the child's hand on the table in front of him as she described the situation, "Your hand is on the classroom table." He might then be told, "You are in school with me, your teacher." In another session she would put his hand on the wall so he could actually feel it while she explained, "This is a classroom wall." The teacher's intrusions would effectively compel Billy to deal with her and to respond to the experience.

Listless children who seem unable or unwilling to use play materials are ultimately seated at a table with a puzzle or a toy with several parts, such as a pegboard. The teacher places the peg in the child's hand and covers it with her own; together they put the peg in the hole.

Intrusions almost always compel the child to deal with reality. With intrusions and physical contacts, the teacher's presence is pushed into the child's awareness. The child must become reality oriented—if only long enough to muster the strength to push the teacher away or get up and move away himself Staff members recognize that a child's negative, resistive behavior is more desirable than unrelated, meaningless activity. They have the sensitivity an judgment to know when such intrusions can help child mobilize himself to respond to his environment

All the children who have come to the Preschoolers Workshop have not made the same degree of progres as David, but most of them have made noticeabl advances. At the end of their first year at the school most of the children looked and behaved more lik other children of their age than they had previously All are able to tolerate a classroom experience fo the entire morning, and most of them can participat in group singing and circle games. Toilet training ha been partly or completely established. Most childre have given up bottles and have learned to handle cup and eat a sandwich with ease. Their comprehension has increased. They use play materials appropriately. They laugh and smile often. Gains made i the first year have usually been augmented and consolidated in the second year.

Such experience offers convincing evidence that th socialization process can be substantially advanced in seriously disturbed, functionally retarded children through a psychotherapeutically oriented nursery school program that provides the child with individualized help at a very young age simultaneously with help to his parents in managing him at home

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Goals and Methods in a Preschool Program for Disadvantaged Children

BARBARA BIBER

Today there are many different kinds of programs for "disadvantaged" preschool children—children who come from families o burdened with poverty that they have been unble to provide the basic early essentials for normal ıtellectual development.[1] While not all children rom poverty-stricken families are so deprived, a reat many of them are and their deprivation shows p in developmental deficits. Different ways of assessng these deficits account for differences in prorams—in the goals they set, in the materials they se, and in their definitions of success.

In describing here some of the methods employed t the Early Childhood Center of the Bank Street 'ollege of Education in New York City and the 'ationale behind them, I must necessarily narrow ny focus to concentrate on the direct work with chilren. I want to point out, however, that the center, vhich was developed under the leadership of Elizaeth Gilkeson, chairman of the college's children's rograms, proceeds on the theory that to work with hildren alone is to invite failure and frustration. t therefore operates as a multipurpose facility with multidisciplinary professional staff working with uxiliary personnel to serve not only the children in he preschool program but also their parents and ther members of their families through the provision of health services, an afterschool program, and a rogram of community relations. In concentrating on the direct work with the children, I will inevitably be giving an incomplete, oversimplified picture.

Behind the center's work is the belief that programs for disadavantaged children should be geared to the same developmental goals set for all children. However, experience has shown that the methods for reaching these goals have to be adapted to the children's developmental deficits. These deficits show up as two main types:

1. **Deficiencies in verbal-conceptual functioning:** Paucity of names for everyday objects; restricted use of qualifying terms; incorrect pronunciation and grammatical usage; immaturity of thought processes that go beyond concrete, immediate experience and depend on language for expression; poor discrimination; a paucity of information.

2. **Deficiencies in how to connect with the world of things and people:** Difficulty in listening, attending, focusing, and sustaining interest or contact; a motoric, staccato, disordered release of energy; difficulty in fitting into a situation that is ordered with respect to time and space; immature ways of dealing with impulses and feelings such as anger, frustration, and denial; expectation that the adult will be distant, denying, punishing; vagueness of self-concept; and so forth.

From our viewpoint at the center, these deficits are regarded as the behavioral manifestations of fundamental faults in the developmental process, and we try to work at what we consider to be the roots of these problems. In doing so, our primary

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Developed from a paper prepared for a meeting of Head Start Regional Training Officers.

goals are: (1) to advance the child's ability to use language functionally and to be able to systematize experience through mastery of conceptual-cognitive processes; and (2) simultaneously to help him develop a solid sense of self and an internalized code of behavior, to build ego-strength in terms of becoming an effective, nonpredatory person, capable of acting autonomously—making choices, taking initiative, setting his own course for problem-solving.

These goals give us a dual mandate: To choose methods for fulfilling the first goal that support and never violate the second goal; and to choose methods for fulfilling the second goal that make the first goal potentially more realizable.

Helping a child with language and thinking requires an understanding of what is behind his inadequacy. At the Early Childhood Center we see a child's impoverished speech, restricted information, and primitive cognitive processes as derived from multiple causes: (1) the absence of models of spoken language that is correct in structure and elaborate in shadings of meaning; (2) an environment in which communication has been limited to the minimum essentials, resulting in a lack of experience in conveying meaning, observation, and feeling and in having one's meaning understood and received with interest and concern; (3) little experience in exploring the physical world in an atmosphere that encourages trying out what can be done with things; and (4) lack of "as if" experience—playing "make believe" or reproducing reality in one's own terms with dolls, blocks, or trains—the basic symbolic experience of childhood that seems to be a prerequisite for subsequent symbolizing with abstract forms.

The program

The center's program, therefore, is designed to initiate the children into many different kinds of experiences: Experiences that, on the sensory level, sensitize them to seeing, feeling, tasting, hearing, and discriminating elements of the environment; experiences that, on the motor level, widen their knowledge of the physical world through their own activity in it—strenuous activity such as climbing, stacking, riding, and steering, and also manipulative activity such as filling pails with pebbles or cutting with scissors; and experiences that, on a symbolic level, develop their representational functioning through painting, building with blocks, dressing up, playing at cooking supper, or pretending that it is moving day.

While providing opportunities for such experiences, the teacher seizes every opportunity for direct interchange with the children, even if only an exchange of facial expressions or gestures when there are no words to share. In doing so the teacher is trying to set up a path of communication, meaning, and feeling that will be translated into verbal form as the child gradually masters the use of language. The goal is to strengthen the capabilities that are the child's underpinnings for learning language, the most important means of human communication, and the symbol system without which higher order cognitive processes—thinking, reasoning, generalizing—cannot be attained.

For the disadvantaged child, the usual developmental sequence cannot be followed. The shift from predominantly perceptive-motor experience to the symbolic stage of verbalization cannot take its natural course. The sequence must be telescoped. At our center the educative process works simultaneously at what would ordinarily be successive stages of development. There is no waiting for so-called unfolding or undefined "readiness." But there is no skipping of the experiences that are needed as solid underpinning for more advanced development.

Thus our approach owes much to the theory of developmental psychologists such as Piaget, Bruner, and others—a theory which has also influenced other programs, for example, those of Sigel [2] and Weikart.[3] According to this orientation, the goal to be accomplished in the preschool years as the basis for competence in language and thinking can be briefly described as having five aspects:

1. To develop the capacity to deal with abstract symbols—words and numbers—by providing the necessary foundation through varied opportunities to know the physical world and human reality through direct, active experience and through communication in symbolic, albeit nonverbal, ways.

2. To develop thinking power by stimulating grouping processes and by encouraging the child to see similarities and differences in the perceived attributes of objects, in functions, in roles played by people, and in the feelings people have.

3. To stimulate ordering processes by encouraging the child to compare sizes, amounts, differences in degree, and the condition of opposites.

4. To establish the basic framework for orientation in space and time.

5. To bring to awareness the variety of transformaions through which change takes place over time, hrough growth or decay or through direct making nd doing in the object world.

By what methods are these goals for advancing anguage and thinking to be reached? Of first imporance is the setup of the school as a learning environment—the kinds of materials presented, the clarity f functional areas, the implicit teaching of "things-n-position" so that the child will learn where to find what he needs, the accent on regularity in a timed world by repeated reference to the sequence of activities, including the child's coming and going, and the vailability of enough adults for each child to have ndividual contacts with an adult in the center and o be known well by at least one member of the cener's staff.

ome techniques

One of the center's highly regarded methods for chieving its developmental goals is to teach the se of language and to advance thinking processes n the context of the child's own activities and play. A few of the specific techniques developed by the eachers for doing this are illustrated here. The exmples have been provided by Jane Catchen and Theodora Sklover of the center's staff.

- Organization of the classroom so that sorting, according to some dimension, is a built-in part of the daily activities.

. picture book in a preschool center becomes both a tool in uilding teacher-child relationships and a stimulus to curisity about how to unravel the mystery of the written word.

Separate shelves are provided for blocks of different shapes. Blocks of the same shape belong on the same shelf. Putting the blocks away involves repeated practice in sorting by sameness of shape. Each shelf is marked with a symbol in the form of the shape of the block. Similarly, other objects also have their own "homes" with like objects.

Jennifer has been playing in grownup clothing and is now putting things away. She moves methodically from place to place—putting the high-heeled shoes on a shelf with other shoes, the long skirt in a box with other clothing. The teacher comments that Jennifer is putting everything with other things just like it.

Jennifer's activities involve the following cognitive operations: sorting and classifying objects and orientating self and objects in space. The teacher translates Jennifer's experience to a more abstract level and introduces an idea of commonness that is not dependent on perceptual likeness.

- Translation of the children's activities into verbal statements; accenting words with tone and gestures.

Teacher to the children who are climbing on the jungle gym: "You're climbing *up*, you're climbing *down*." Going up to the play area on the roof of the center's building: "We are walking *up*—let's look *up;* let's walk with our hands *up;* let's jump with our hands *down*."

At a later stage, going to the roof becomes more than an up-down learning experience. The teacher calls attention to what the children pass on their way—a radiator, another door, and so forth. She asks, "Is this the door to the roof, or is *this* the door to the roof?" The teacher is stimulating the children to analyze the passing perceptual stimuli and to weigh the relevance of what they see to their ultimate destination. Thus they are learning both to discriminate perceptually and to think in terms of a pathway to a goal.

The teacher establishes the custom of having the children call out the names of the objects on the roof as they see them in approaching the play area. One day she introduces a variation: "Let's go a different way this time," choosing alternative paths around the equipment. This stimulates the children to appreciate the sameness of objects seen from different perspectives.

- Work on formal aspects of language usage as part of ongoing communication with the children, while keeping in mind the importance of not violating the child's efforts at communicating in nonverbal ways and of maintaining her role as an adult who cares about meeting the child's wishes.

Teacher to the child: "What do you want?" The child points to an object on the shelf. Teacher: "You want the red truck. Say: 'I want the red truck.'" The child refuses. After one repetition, the teacher says: "You can say it next time." She gives the child the truck.

- Encouraging problem-solving by putting into question form the things children are confused about, stimulating them to ask questions themselves, and guiding them to sources of information.

While reading a story about firemen, the teacher recalls the children's confusion about the many different roles people carry. She asks: "Is a fireman a daddy?" The children answer, "No." The teacher is clearing the way for the children to learn from each other; she knows that one child's father is indeed a fireman and this child will contribute the answer that will enlighten the others.

Further reading of the same story leads to other questions: What do firemen do? How does water get into the truck? Where do they get it? The teacher encourages the children to guess and tells them they can check their answers with the firemen. Later she takes them to the firehouse, where they ask their questions.

The teacher asks the children if they know any place on the street where they can get wet. They describe the fire hydrants, which in some streets of New York are opened on hot days for children's water play. The realization that the firemen come to the same place they do to get water thrills them. The teacher supplies the word "hydrant," and takes the children out walking to spot the hydrants in their neighborhood.

This experience stimulates dramatic play—building fire engines with large blocks. For these children, dramatic play often needs priming and, at first, they prefer to use themselves rather than miniature figures as the actors.

- Introduction of written symbols in a way that is functional to the children's activities.

In each of the rooms the paintings done by the children are displayed with a large clear name label attached to each. In the room for 4-year-olds each child is asked to turn over the card with his name as he comes into the room.

A little girl asks to visit in another room. The teacher writes a note in her presence, tells her she can go "tomorrow," giving her the name of the day, and posts the note on the blackboard. When the child forgets the next day, the teacher reminds her, repeats the name of the day, and arranges for the visit.

Prestructured experiences

Another method for advancing verbal-conceptual skill is the more familiar use of planned lessons and readymade materials for teaching specific aspects of such skill. Materials for providing prestructured experiences—such as form boards, Lotto games, matrix games, the electric typewriter—are abundantly available today, since innovation has been prolific in this area. Planned lessons are part of every trained teacher's repertoire and are today more highly developed and systematized than they once were. Nimnicht's "learning episodes" are, perhaps, the most elaborate.[4]

Such readymade materials and prepared lessons—except those that are strictly programed or automated—are very much in use in the center. They are valuable in separating the mental maneuvers involved in dealing with concepts of similarity and difference between pure shapes and forms from the analogous thinking processes that take place in the context of complex life situations. They serve the functions of rehearsal and consolidation. By requiring the child to deal with abstract symbols, they prepare him for the later task of processing the symbols of a printed page. They also provide the child with the gratification of succeeding at a clearcut task.

The teachers at the center preplan sessions aimed at promoting the learning of specific concepts—color, size, shape, and the like. In such sessions any given concept appears over and over again in a wide variety of contexts. For example, the color orange is first brought to the children's attention through showing them an orange (the fruit) itself. Then the children play a game to spot the color elsewhere in the room—on some of the children's clothing or on a pumpkin the teacher has brought in. Easels are set up and the children are given only yellow and red paint; they delight in finding that orange comes through when one color is put over the other. The children are given orange transparencies to look through.

In addition to supplying varied contexts involving a common phenomenon, the teacher tries to lift the level of fun and pleasure and to introduce dramatic, unexpected turns. Thus, she helps the children focus their attention on the activity in which she is engaging them.

The center's teachers alternate between teaching directly, with the use of planned learning episodes or readymade materials, and indirectly eliciting learning through bringing the relationships that are implicit in their activities to the children's awareness. Often they use both methods to help the children go through the same conceptual process—for example, dealing with the important question of how things can be the same in one way and different in others.

In one group the children were bothered by differences in two books about the story of Mary and her little lamb. The teacher cued into their annoyance and used it to further their growth. She called attention to the different houses each of them built with blocks. She showed them a grapefruit and a lemon (both yellow fruits but one much bigger than the other) and cut them open so that the children could see the difference in the seeds. Then she brought out the materials that require the child to work with the concept of similarity and difference on an abstract level, asking them to find the triangles, regardless of differences in size, among an assortment of other shapes.

Building motivation

Thus far I have alluded only to the question of motivation in the methods we use to advance the children's verbal-conceptual skill. At the center we do not use rewards like food or stereotype forms of praise through words or gestures, nor do we use punishment. Instead, we build motivation through other means: One is by relying on the intrinsic pleasure and satisfaction of learning and becoming skillful and knowledgeable; another is by grounding learning in the real experience of living; another is by building a special kind of relationship between the children and all those who stand in the teaching role.

The question of motivation carries us back to the second area of developmental deficits observed in the disadvantaged child at school; his poor ways of connecting with things and people. Such deficits show up in the extremes of withdrawal and inhibition exhibited by some children and in the tempestuous, unfocused behavior of others; in a transient relation to objects; in a lack of sustained interest or attention; in an absence of modes of coping with impulses of destruction or feelings of anger and fear; in an inability to fit into an ordered environment; in perception of adults as restricting, denying, or punishing. In short, the disadvantaged child, being uncertain about himself and who he is, feels that he is at the mercy of unpredictable adults whom he cannot trust to be on his side.

Behind this shaky position in life are several possible causes. For some children, it can be attributed to the lack of an active, meaningful connection with people in their earliest years, to their having missed the experience of being listened to, played with, noticed, and understood as individuals. For other children, it goes back to even more debilitating conditions: Inconstant and traumatic relationships; uncertain care and protection; threats and punishment that are often only randomly related to their behavior; punitive suppression of their assertive or exploratory drives; exposure to frightening, often violent, behavior on the part of adults.

At the center we proceed on the premise that these deficits—the fears, the inhibitions, the uncontrolled impulses, the distrust of people—can be ameliorated gradually through the development of a particular kind of relationship with a teacher, a relationship that offers wholehearted support while it controls and channels behavior. Here the teacher's choice of method is tied not only to the goal of establishing the emotional equilibrium needed as the basis for learning, but also to the goal of developing an autonomous, self-initiating human being.

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The question of how to achieve these goals requires as much analysis and experimentation as the search for methods of developing verbal-conceptual skill. I would like to stress four points:

1. As her fundamental task, the teacher makes every effort to understand the child's wishes and needs; she "takes responsibility to recognize the bases of his strivings and to help him harness them to a learning task which he is able to recognize as consistent with his desires and goals."[5]

Remembering the child's deficit in important relationships with people and his sense of distrust toward those who have power over him, the teacher invests energy and imagination in finding ways of making contact with him and building up an image for him of an adult as a giving, supporting, caring person. She not only expresses pleasure in the child's accomplishments, but shows as much affection as the child can accept, often doing so through physical contact—touching, soothing, taking the child on her lap. She listens hard for the meaning the child is trying to convey with his poor speech and protects his early efforts at communication by giving his message back to him in correct form while sparing him the negative impact of correcting his usage.

2. The teacher activates the theme of giving to the children; she does not rely on them to be able to take on their own initiative the opportunities laid before them. She introduces them to the use of equipment, demonstrates as much as tells, joins them in exploring

the toys and other things around them, and starts them off in using the housekeeping corner as a way of sifting and rehearsing their experiences. The teacher fulfills the basic giving function of her role as a teacher by leading the child to greater use of his powers to do, to make, to speak, to think. She does this in much the same way that she works for verbal-conceptual development while making the school environment a known, understood, manageable world for children.

3. The teacher manages the task of socialization—helping the child to control unacceptable behavior—by redirecting his drive to alternative channels. When she stops children from fighting, she says, "You could fix it with words," thereby offering them an alternative in the idiom of childhood. When a child is disrupting other children's play by throwing a ball wildly in their midst, she leads him to a place where it is all right to throw a ball. When she stops a child from dashing out of the room, she asks him where he is going and why he needs to go there. Her intention is not to elicit answers—she knows his running comes from an inner drive or turmoil and has no direction—but to initiate an exchange of communication that may help him begin to integrate purpose into his actions to replace his aimless release of energy.

Helping a disadvantaged child learn to get along with others requires constant repetition of such techniques until the child can internalize control and establish purpose for himself. It is important that during the process the child is experiencing a new kind of control: the authority of a closely involved, caring adult, the same person who also respects his wishes and offers him opportunities for free choice. Thus a foundation is being laid for a relationship through which trust might replace distrust.

4. The teacher engages the children in analysis of the component parts of situations in which she must exercise control of their impluses. Thus she helps the children perceive specifically what is happening. From the viewpoint of cognitive development, this is another experience in differentiation; from the viewpoint of socialization, it is a means toward maintaining rational rather than arbitrary control.

Sometimes this happens when the teacher is trying to explain the children to each other. For example, three children are impatiently waiting for a turn on the much-prized tricycles. The teacher articulates the children's feeling for them: "It is hard for John to wait; it is hard for Susie to wait." Thus the cognitive task of finding the common elements among differences is being exercised in the sphere of human feeling.

In another instance, the teacher tells an impulsive child who is set to rush into the elevator ahead of the others that he can be first to go in when he has learned how to manage the buttons so that he can push the one that will make the elevator go to the right floor. The teacher is channeling the child's drive to the task of discriminating between the symbols on the buttons, thus giving him an opportunity to focus on a goal and master his own actions within the limits of permissible behavior.

It is especially important for disadvantaged children to become perceptive in the sphere of feelings and human relations and to differentiate between people in terms of what to expect from whom. The knowledge they gain in the human-social sphere is at least as crucial for remedying the deficits of their early years as is the mastery they acquire in processing information about the physical world.

The following incident illustrates how learning can take place within a relationship of mutuality between teacher and child. A teacher found a little boy cuddled in a cubbyhole with head on hand. "I s'eeping," he announced. She acknowledged the game and then said, "Say *sl*eeping." No reply. She shaped her lips; she made the sound "*sl*." No reply. She said, "You can say it another time." Several hours later when the same child was boarding the bus to go home in the afternoon, he turned to her grinning and said, "*sl*eeping." He had learned from his teacher while allowing himself the strength of assertion by refusal; and he reciprocated by giving her what she wanted from him.

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why children are in jail

AND HOW TO KEEP THEM OUT

JOHN J. DOWNEY

Every year in this country, about 100,000 children under 18 are locked up in jails, according to estimates of the National Council on Crime and Delinquency.[1] Jail detention is not only harmful to children emotionally and morally, and thus likely to produce further delinquency, but it is also unnecessary. In fact, many children who are held in jail do not need to be detained at all.

During the past 7 years, the Children's Bureau has studied 18,000 cases of children in jail and the police and court practices that put them there. These studies show that—

1. In spite of State laws apparently intended to protect children "from the evils of jail," most such laws and the ways they are administered do not keep children out of jail.

2. Most children held in jail do not need to be locked up anywhere. They are unnecessarily confined for many reasons, including the use of jail for punishment or "treatment," poor court policies in relation to the detention of children picked up for delinquent behavior, and the lack of open shelter care facilities for children who need temporary care, but not secure custody, while awaiting disposition of their cases.

3. Of the children in jail who do need secure detention, many require it for only a day or two.

4. Even the assumption of responsibility for detention by the State, through the provision of regional detention facilities, does not keep children out of jail.

These findings strongly suggest that children can be kept out of jail, even in a small county, by the enactment and enforcement of laws prohibiting the holding of children in jail, by establishing sound court policies for admission of children to detention, by making arrangements for open shelter care of children accused of delinquency who need such care, and by establishing facilities for holding children up to 48 hours who need secure custody locally until other arrangements can be made for them.

The Children's Bureau investigated the 18,000 cases of children in jail in the course of 23 studies of detention practices. Eight of these studies were statewide; two were studies of State regions, embracing eight counties; and 13 were studies of individual counties. In all, the studies looked into the detention needs and practices in 279 juvenile court jurisdictions covering 264 counties in 18 States. In 1960, these 264 counties had a total population of 17,324,429. High density population areas were not proportionately represented in these studies. Because most large cities contain detention homes, delinquent children are less likely to be held in jail in such areas.

The studies recorded the circumstances surrounding each child's jail detention, including the offense that led to his apprehension, the length of stay, and the child's destination upon release, all factors bearing on the necessity for detention. The studies also looked into the laws and practices under which the children were admitted to jail and the reasons given by the local authorities for putting them there. Because of the variations in availability of information among the jurisdictions covered, the recording on all the factors of interest was not complete for all jurisdictions. However, sufficient data were recorded to reveal why children are being placed in jail and to indicate what action is needed to end this practice.

In this article, the term "delinquent" will refer to the child who is alleged delinquent as well as to the child who has been adjudicated as delinquent. "Detention" means the temporary care of children in secure custody pending court disposition. "Shelter" means the temporary care of children in physically unrestricting facilities pending court disposition.

A question of legality

A review of the laws concerned with juvenile offenders in the 18 States in which these studies were made reveals an apparent intent to keep children out of jail, for they all contained a phrase like "no child shall be held in any jail, police lockup . . . ." This phrase, however, is usually followed by a qualifying phrase such as "unless ordered by the court," or "unless they are held in quarters separate and apart from any adult . . . ." Such a qualifying phrase provides the loophole through which children can be legally placed in jail.

In several of the 18 States, however, the law clearly prohibits placing children under 14 years of age in jail. In one of these 18 States, children under 16 cannot legally be put in jail. Even in these States, however, the studies show that the law is often ignored and children under the permitted age are held in jail.

Furthermore, the studies show that many of the children held in jail are not afforded the right of due process. They are placed in jail by law enforcement or probation officers and later released without ever having a petition filed with the court in their behalf or without ever having a hearing in court.

Was detention necessary?

The children's offenses. The offense that has led to the child's apprehension gives an indication of the severity of aggression or rebellion in his behavior and of whether or not he may be a danger to himself or others. While the offense should never be the sole factor in the decision to detain a child, it should certainly bear much weight in that decision.

The Children's Bureau obtained data on the specific offenses of 9,177 jailed children. Less than 4 percent were "offenses against persons," such as assault or robbery. On the other hand, slightly over 41 percent consisted of acts that would not have been violations of law if committed by an adult—running away from home, truancy, curfew violation, possession or drinking of alcoholic beverages, and "ungovernability." (See table 1.)

Runaways, it is true, need to be held until they can be returned to their parents. Some of the children called "ungovernable" may need emergency shelter care. Since these offenses are not singled out in the data, any specific conclusions as to the extent of unnecessary detention cannot be drawn from these figures. However, the low figure on offenses against persons indicates that very few of the children who were held in jail could be considered "dangerous." And the high figure on children jailed in facilities

Table 1.—OFFENSES OF 9,177 CHILDREN IN JAIL

Type of offense	Number of children 9,177	Percent 100
Offenses against persons	348	3. 8
Offenses against property and other violations of law	5, 011	54. 6
Acts that would not be violations of law if committed by an adult	3, 818	41. 6

Table 2.—LENGTH OF STAY IN JAIL
For 15,840 Children

Length of stay (days)	Number of children 15,840	Percent 100
2 days or less	11, 148	70. 4
3 days or more	4, 692	29. 6

for adult offenders who if they had been adults could not even have been arrested for their offenses suggests an ironic discrimination against juveniles.

Length of stay. How long a child is held in jail sheds some light on how necessary it was to confine him in the first place, for a child who is a danger to himself or others is not likely to be released prior to a court hearing unless he is to be removed to another jurisdiction.

The Children's Bureau obtained data on how long 15,840 children were held in jail. More than 70 percent were held 2 days or less. (See table 2.)

Two days or less is an appropriate length of time to hold children in secure custody who are to be returned to other jurisdictions, such as out-of-county and out-of-State runaways or parole violators. But being held in secure custody at all hardly seems appropriate for children who can be safely sent home to their parents or someone else in the local community in a day or two. When children can be released after such a short stay in jail, the necessity of having locked them up at all is open to question.

These figures show that even if all the jailed children *had* required secure custody, 70 percent of them could have been kept out of jail if facilities for holding children securely up to 48 hours had been available locally.

Destination on release. However, information obtained on the children's destination on release from jail strongly suggests that only a small proportion of the children needed secure custody for even a short time. The Children's Bureau obtained data on the destination of 14,136 of the children. Of these children, 2,739 were returned to other jurisdictions. Local authorities disposed of the other 11,397 cases. Of those whose cases were handled locally, about 80 percent were allowed to remain in the community. (See table 3.)

In addition to children who must be held for other jurisdictions, those children most likely to require secure detention after being picked up for delinquent behavior are the extremely aggressive youngsters who may continue making trouble if released to the community. One would, therefore, expect to find that a high proportion of jailed children had on release been removed from the community through commitment to State agencies or institutions by local court action or had been transferred to adult courts for trial. However, the figures show that only about 20 percent of the children whose cases were handled locally had been committed to agencies or institutions or transferred to adult courts.

Admission to detention

A comparison of court policies in 22 of the 23 areas studied showed that fewer children were jailed in areas where the courts exercised control of the admission of children to jail. (One of the States studied was omitted from the comparison because of the wide variation of detention practices within its several court jurisdictions.) In 12 of the areas, police had put children in jail without making any contact with the court or the probation officer. Although these areas contained only 26 percent of the total population of the 22 areas (according to the 1960 census), they had 47 percent of the jail admissions of children. In the 10 other areas—with 74 percent of the total population but only 53 percent of the jail detentions—the police were required to check with court authorities before putting any child into jail.

In 10 of the areas studied, one or more of the court officials responsible for screening children for detention reported that they often sent children to jail as punishment even though the children did not need secure custody. In one State some of the judges had

Table 3.—DESTINATION ON RELEASE FROM JAIL
of 11,397 Children Whose Cases Were Disposed of Locally

Destination	Number of children 11,397	Percent 100
Sent home or otherwise left in community	9, 222	80. 9
Sent to correctional institution or transferred to adult court	2, 175	19. 1

such little confidence in the rehabilitative ability of the State training school for delinquents that they preferred holding a child in jail for a period of time to committing him to the school.

The existence of a detention home did not always keep children out of jail. In four of the counties studied, detention homes were available but the courts were holding children in jail by choice. In three of these counties, the detention homes were not equipped, from the standpoint of program, building, or staff, to handle the kind of troublesome adolescent who needs detention. In the fourth county, children were routinely placed in jail before being sent to the detention home.

Children were also in jail—2,366 of them—in the two States studied that operated regional detention systems. They were put there by the court's choice, through routine admission practices, or to await placement in the regional detention home.

The first step toward eliminating the jailing of children is the enactment of laws that would not only prohibit this practice but would also assure the proper use of detention or shelter care. Where necessary, the statutes should be complemented by appropriate court rules and policies. Together, the law, court rules, and policies should provide—

1. **Criteria for admission.** A child taken into custody should not be placed in detention or shelter care unless such care is required to protect the person and property of others or of the child, the child is likely to leave the jurisdiction of the court, or the child has no parents, guardian, or other person able to care for him and return him to the court when required.

2. **Procedure to be followed.** The law enforcement officer who takes the child into custody should immediately: (a) release the child to his parents, guardian, or custodian upon their promise to bring the child before the court when requested unless his placement in detention or shelter care seems to be required for his own or others' protection; (b) take the child to the court or place of detention or shelter designated by the court and immediately give written notice of this action and the reason for it to a parent, guardian, or other custodian of the child as well as to the court.

When a child is taken to a court or place of detention, the probation officer should review the request for detention before admission and should release the child unless detention is necessary.

If the child is not so released, a petition for court action in behalf of the child should be filed within 24 hours. A hearing on the necessity for detention should be held within 24 hours after the petition is filed. Unless the court finds that the child's detention is required, it should order his immediate release.

3. **Twenty-four hour intake.** The court intake officer should be available on a 24-hour basis—either on duty at the court, the designated place of detention, or on call—to authorize the detention, shelter, or release of children referred by the law enforcement officers.

4. **A prohibition against jailing children.** The legislation should set a date after which the placement of children in jail would be absolutely prohibited. This date would allow a short interval for the provision of appropriate facilities for the temporary care of delinquent children.

Shelter care

Specific figures on how many children needed shelter care rather than secure custody while awaiting disposition of their cases are not available from the Children's Bureau studies. However, the need for facilities to provide this type of care was so obvious in many of the communities under study that recommendations for their establishment were contained in 18 of the 23 studies. In New York State, where there are about 25 facilities for shelter care, the communities operating them have experienced a noticeable reduction in the number of children in secure detention.[2]

A shelter home differs from a detention facility in having no security features such as locked rooms and barred windows. It can be a group home owned by a social agency such as the county welfare department and operated by a salaried staff; or it can be a foster family home subsidized with a flat monthly fee for the foster parents' services, plus board for each child on a per diem basis. In either case, the shelter home should be reserved exclusively for temporary care and should be ready to accept children at

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any hour of the day or night. A foster family home should be limited to caring for no more than six children at a time; a group home, to no more than 12.

While such shelter facilities are not secure lockups, the children they serve are often difficult to handle. They need care from understanding adults who can involve them in constructive activities and who are capable of providing close supervision to a child when he is upset, even if this means staying up with him at night. Adequate compensation and provision for relief personnel are necessary to keep the group homes staffed and the subsidized foster families willing to continue in a task that provides few of the satisfactions of long-term foster care.

Provision for the temporary shelter care of children picked up by the police is necessary even where there is an adequate detention home. Such provision can be made on a small or large scale, depending on the size of the community.

Holdover facilities

A facility providing secure custody for apprehended children for no more than 2 days can allow the court reasonable time either to dispose of the case or to make arrangements other than jail for the child. Such a facility is needed in every community where a detention home is not readily accessible. It can be in a separate building or in a building used for other purposes, but never in a jail.

Because the children in its charge stay for such a short time, the local holdover facility does not have to provide space for large-muscle activity as does a detention home, which may hold children several weeks. Further, since in most instances a holdover facility contains very few children at any one time, the children can be under constant supervision. Thus, while keeping the facility locked is important, there is not the same need for the type of construction and equipment required in a regular detention home to prevent a child from hurting himself or others.

In Utah, local holdover facilities are being developed throughout the State. The Utah Department of Public Welfare has established written detention standards with 48-hour holdover facilities designated as "Type C." [3] Such facilities are already in operation in Cedar City, St. George, and Price and one is under construction in Logan. Generally, these facilities have from four to six individual sleeping rooms, a day room, a shower room, and a supervisor's office. Each facility contains a refrigerator and stove for preparing snacks and meals for newly admitted children, but regular meals are brought in from other institutions or consist of TV dinners.

Sometimes such holdover facilities for children are provided for in new buildings constructed to house other activities. For example, in Cedar City, Utah, the holdover facility is in the basement of a new county hospital; in St. George, it is in the basement of a new county office building. When a holdover facility is located in an institution caring for other people, it is important that the children be kept in separate quarters out of sight and hearing of these other people.

In a small community, a secure holdover facility for children may not always be in use, thus posing a problem of staffing. In Utah, the problem has been solved by employing a couple in each community on a standby basis. Each couple is paid a monthly salary and is called to the facility for duty when children are placed there.

A local 48-hour holdover facility is not a substitute for a detention home that can provide secure care for children for as long as 3 weeks, if necessary. Risks are involved in operating a short-term facility unless such a detention home is available somewhere in the State to which children who need to be held longer can be transferred. If a regular detention home is not available, the court will be forced to make a disposition of children in the local facility's care within 48 hours. When the child is well known to the court, this should be sufficient time for a wise decision. In other cases, however, a quick disposition before the probation officer has been able to complete his study is risky. A child may be released to the community who is not ready for community living and another child may be unnecessarily committed to a State institution. However, even when a regular detention home is not available, the establishment of a local facility for holding children securely up to 48 hours can eliminate the jailing of children.

If jailing children is to be stopped, there must exist the firm conviction that jail is no place for a child—a conviction followed up with the enactment of appropriate legislation, the establishment of sound court policies for admission to detention, the development of local arrangements for shelter care, and the provision of local 48-hour holdover facilities. Children can be kept out of jail where there is a will to keep them out.

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[3] Utah Department of Public Welfare: Minimum standards of care for the detention of children. Salt Lake City, Utah. 1961.

We have juvenile delinquency when the young overappraise freedom in action. They believe that because they can think it, they can do it. We have adult delinquency when the custodians of culture underappraise freedom in thought and speech. They believe that because they can't do it, the young should not do it, or even think it. The adult variety is the worse, for it crucifies the life, the imagination, the fountain, veritably, from which all values flow.

Thomas Vernor Smith, Professor Emeritus of Poetry at Syracuse University, to the 1960 White House Conference on Children and Youth.

facts against impressions:

Mothers Seeking to Relinquish Children for Adoption

HAL K. PLATTS

Social workers often suggest agency policy changes on the basis of "trends" they notice in their clientele. Early in 1965 at the Department of Adoptions in Los Angeles County, Calif., two such "trends" among mothers who were considering relinquishing an expected child for adoption were identified almost in unison by the caseworkers: (1) a "significant increase" of women who had previously relinquished a child for adoption, and (2) a "surprising increase" of married women who were still living with their husbands. Some of the caseworkers thought that as many as 30 to 40 percent of the expectant mothers who were considering relinquishment of a child were "repeaters" and that 10 to 20 percent were married to and living with the father of their expected child. If these observations were valid, they obviously had implications relating to the effectiveness of the agency's past services and its policies for the future. But were they valid?

Observations made by one worker or even several workers in a small agency can easily be evaluated and dealt with, but when similar observations seem to be coming from as many as 35 workers employed in five district offices, the task of pinning them down is more exacting. Faced with the latter situation, the Los Angeles County Department of Adoptions undertook a survey. All its staff members who were working with mothers in the agency's relinquishment program or with mothers who had already placed a child for adoption independently, were asked to fill out a questionnaire on all such cases active as of March 7, 1966—a total of 1,513 cases.

The findings did not validate the trends the social workers observed. The findings on 1,062 cases in the agency's relinquishment program particularly failed to support the suspected trends.

Methods and limitations

The questionnaires asked for case number, district, type of case (independent adoption or agency relinquishment), mother's age, marital status, ethnic background, number of children previously relinquished to the agency, number of children not relinquished, number of children born out of wedlock, and paternity of the child for whom relinquishment was being considered ("mother married to child's father or mother never married to child's father"). The workers throughout the agency were requested to complete the form on the same day for each mother under care.

The foregoing categories were selected arbitrarily to encourage uniformity. The completed forms were processed by the Los Angeles County Department of Public Social Services.

Several problems in collecting and interpreting the data tend to limit the significance of the results. Cases being transferred or just opened were not considered active. An unmarried mother who had previously received service from the agency but who had kept her child could not be distinguished in the statistics from the mother who had had a previous child out of wedlock but had not received service from any agency. There was no way of knowing whether a mother now being served had previously relinquished a child, aborted, or had borne other children out of wedlock if she had not reported this fact to the worker or had not received service from a California agency in connection with it. Although the instructions for the questionnaire were fairly clear, some data turned in were obviously incorrect.

The foregoing problems were those most pertinent to the agency's purpose, which was to get a better picture of the agency's clientele. Because of them, and other shortcomings, the survey cannot be regarded as wholly reliable. It would be incorrect to make broad assumptions based on its findings. However, despite the survey's limitations, the description of the client population that can be derived from it is much more accurate than the suppositions of the past. The agency had never before looked at its population in such a systematic manner. In doing so, it received several surprises. The results of the survey have raised many significant questions in regard to agency policies and have brought several suggestions for change.

Ethnic derivation: The questionnaires required the social workers to designate the ethnic backgrounds of the mothers according to four categories that are closely related to the lines usually followed by the agency in matching a child to prospective adoptive parents: (1) *Anglo*—a colloquialism used in th Southwest for all Caucasians of European derivatio except the Spanish-speaking; (2) *Negro*—a designation given to any mother who reported herself to b Negro or part Negro; (3) *Mexican*—a rather loos designation for persons of Mexican descent or of an Spanish-Indian mixture; and (4) *other*—Oriental and others who do not fit into the three previou designations.

According to these designations, 81 percent (864 of the 1,062 mothers in the relinquishment progra were Anglo; 10 percent (101) were Negro; 6 percen (64) were Mexican; and 3 percent were classifie as "other". In comparison with the ethnic composition of Los Angeles County as a whole, these figure show a larger proportion of Anglos than the count proportion of 74 percent and a smaller proportio of Mexicans than the county proportion of 12 percent for a group designated as "Spanish surname. The proportions for the Negro and "other" group are closer to the county's, which are 11 percent an 2½ percent respectively.

Marital Status: Of the 1,062 mothers in the relinquishment program, 63 percent (673) had never bee married; 10 percent (108) were married and livin with their husbands at the time of the survey; 1 percent (121) were separated from their husbands 12 percent (127) were divorced; and 1 percent (6 were widowed. The marital status of the remainin 3 percent was unknown. There were differences between mothers of different ethnic groups: 56 percen of the Mexican mothers had never been married compared with 63 percent of the Anglo mothers an 76 percent of the Negro mothers.

Eighty-one mothers, or 7.6 percent of all thos being served in the relinquishment program, wer considering relinquishing an expected child fathere by their own husbands—a smaller percentage tha expected. Of these mothers, 49 were still living wit their husbands, 17 were separated, and seven wer divorced. Most of these mothers were Anglo—45 o those still living with their husbands, 16 of the separated, three of those in unknown status, and seven o the divorced.

Age: The social workers in the agency tended t think of the typical unmarried mother as a teenage in her last year of high school. The survey showed however, that while most of the mothers being serve by the agency were unmarried, 622, or 59 percent o the total, were at least 20 years of age; 35 percent

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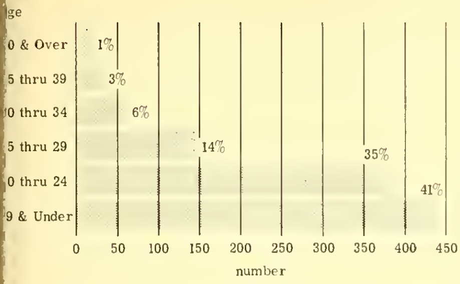
1,062 MOTHERS SEEKING TO RELINQUISH A CHILD FOR ADOPTION



ere from 20 through 24; 14 percent were from 25 rough 29; 6 percent were from 30 through 34; 3 ercent were from 35 through 39; and 1 percent (15 others) were over 40. These figures show an even naller proportion of younger mothers than the tional statistics on unmarried mothers for the year 966, but on the whole the proportions for age groups e similar. According to the National Center for ealth Statistics 47 percent of the 135,800 women ho gave birth out of wedlock that year were under) years old; 31 percent were age 20 through 24; 12 ercent were 25 through 29; 6 percent were 30 rough 34; 3 percent were 35 through 39; and 1 ercent were over 40.[1]

While 41 percent of all the mothers in the agency's elinquishment program were under 20 years of age, nly 22 percent of the Mexican mothers were this oung. This difference may be related to the fact that e Mexican group included a smaller proportion of others who had never married than did the other wo ethnic groups in the study.

Repeaters: Not counting 28 mothers on whom no nformation concerning previous relinquishment ould be obtained, less than 9 percent (91) of the others had previously relinquished a child. The ercentage was higher for mothers who were still arried (12 percent) or who had ever been married also 12 percent) and in these groups the previous elinquishments had been made largely by Anglo others. However, among all of the mothers in the rogram, the "other" and Mexican categories inluded the largest proportions of such repeaters: 14.3 ercent of the "other" mothers and 13.3 percent of the Mexican mothers had previously relinquished a child, compared with 8 percent of the Anglo mothers and 6.7 percent of the Negro mothers.

Several parents had relinquished more than one child—12 had relinquished 2 children; three, 3; and two, 4. Of these mothers, 14 were Anglo; one was Mexican; one, "other"; and none, Negro.

As could be expected, the repeaters as a group were older than the relinquishment program's clientele as a whole: 84 percent were 20 years of age or over. Fewer had never been married—49 percent; and more (17 percent) were still married and living with their husbands; more (17 percent) were separated; and more (17 percent) were divorced.

Overlapping this group of repeaters in the agency's relinquishment program was another group analyzed: All mothers reported to have previously had a child out of wedlock whether or not they had relinquished the child for adoption. Here the findings showed a somewhat different breakdown in ethnic origin. Whereas only 6.7 percent of the Negro mothers had previously relinquished a child, 43 percent of them had previously had a child out of wedlock. Among the Mexican mothers, 30 percent had previously had a child out of wedlock; and among the Anglo mothers, 14 percent.

Independent placements: A comparison of the data on the 451 mothers who had independently placed a child for adoption with the data on the mothers in the agency's relinquishment program, shows that the "independent" mothers were on the whole older—72 percent (compared with 60 percent) were at least 20 years old; a higher proportion were Anglo (88 percent compared with 81 percent); fewer were Negro (5 percent compared with 10 percent) or Mexican (4 percent compared with 6 percent); and fewer had never been married (53 percent compared with 63 percent). A slightly higher proportion of mothers in the independent group had previously relinquished a child for adoption (11 percent compared with 9 percent); and a much higher proportion (over 5 percent compared with less than 2 percent) had previously relinquished more than one child.

Some implications

Researchers have long maintained that shared impressions from observations are frequently misleading and should be put to the test of a more scientific approach to factfinding. The results of this survey support this point of view rather dramatically. They represent valuable information that the agency did not expect. Before the survey, some staff members of the agency had assumed that up to 40 percent of the mothers considering relinquishment were recidivists and that up to 20 percent were married and still living with their husbands. The survey showed, however, that fewer than 9 percent of the mothers considering relinquishment had previously relinquished a child for adoption, and that no more than 5 percent were considering relinquishing a child fathered by their own husbands with whom they were still living. The correction of the previous misconceptions by such facts obviously has implications for agency policy.

Other findings that dispel assumptions previously held by most of the social workers in the agency were:

- The great majority (nearly 60 percent) of the mothers in the relinquishment program were at least 20 years old.
- A greater majority (78 percent) of the Mexican mothers were at least 20 years old.
- A large proportion (37 percent) of the mothers had been married at some time.
- The proportion of Anglos in the agency's clientele was greater than the proportion of Anglos in the community at large.
- A greater proportion of Anglo mothers were repeaters than of minority group mothers.
- While few Negro mothers in the relinquishment program had previously relinquished a child, 43 percent had previously had a child out of wedlock.

What was learned about the age of the mothers being served indicates that the agency does not need to expend as great a proportion of its effort as the staff had thought necessary in working with maternity homes, high schools, and other community agencies to develop resources for teenage expectant mothers. Rather, knowing that 60 percent of the mothers in its program are 20 years of age or older, it might shift its planning emphasis to the development of such resources as foster homes and day-care centers for children, financial assistance, vocational training centers, and family planning services. In working directly with its clients, it might logically put more emphasis on problem solving, crisis intervention, and joint interviews with both mother and father of the child being considered for relinquishment.

While the married mothers living with their husbands are not as significant a part of the agency's clientele as expected, one fact learned about them needs careful attention: in more than 50 percent of these cases, the expected child had been fathered by a man other than the husband. The complexity of such a situation requires a great deal of skill on the part of the caseworker. The particular techniques needed for helping a mother in such a situation should be identified so that new workers can learn them rapidly. Such a potentially explosive area of casework ought not to be left to a person who is learning through trial and error.

The findings in regard to the ethnic origins of the agency's clients raise many questions. Why is the Anglo client disproportionately represented? Do Anglos have the greatest need for the agency's services? Does the large proportion of mothers in the Negro group who have had previous children out of wedlock suggest a lack in the agency's service or at least suggest new areas of service? Should the agency be more active in developing other resources in the community to serve Negro unmarried mothers and their children for whom adoption does not seem feasible? Is the agency doing as much as it can to make adoption feasible for Negro children? Is the agency as accessible to clients from minority groups as it is to Anglos? Does the availability or lack of potential adoptive homes for members of the different ethnic groups affect the quality of the agency's casework in an unhealthy way?

With all its limitations, this survey has increased the agency's awareness of many important points about the nature of its clientele. It confirms the importance of learning the facts instead of relying on impressions.

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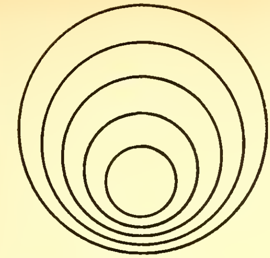
[1] U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics: Vital statistics 1966, Vol. I: Natality. Washington, D.C. 1968.



an essay review . . .

THE COMPLEXITY OF INFANT DEVELOPMENT

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People who seek to find their way through the burgeoning and often confusing literature on infant development will be reassured at discovering Sibylle Escalona's "The Roots of Individuality." * In her preface, Dr. Escalona notes that the preparation of the book took place over a span of 20 years. During that time she was engaged in several different studies of infancy as well as in clinical work as a child psychologist and in other professional activities. Her developmental approach to the production of her book has much to do with its value. It contains a rare and felicitous combination of carefulness of formulation, precision of observation, and theoretical sophistication. One of Dr. Escalona's most important contributions to infancy research and to research in child development in general, I believe, is her steadfast insistence upon the complexity of development even in the earliest years.

This book is divided into three major sections. The first section deals with current trends in research, though, as Dr. Escalona says, a complete review of the literature would require a book in its own right. She has done something infinitely more helpful in electing to focus on several of the more relevant types of studies. Moreover, almost every paragraph of the first 20 pages contains a summarizing or integrating statement that, for those of us who have long been involved in infancy studies, is a pleasure to find. Such statements will also be useful guidelines for the student of child development and for the young investigator.

One point to which Dr. Escalona calls attention is a change in perspective in studies of neonatal reflex behavior. Before the 1940's, studies of neonatal reflexes were focused mainly on the clinical significance and prevalence of such reflexes; since about 1950 such studies have been increasingly focused on what Dr. Escalona calls the adaptive and developmental role of reflex activations. She points out, for example, that the rooting reflex has been the subject of study not only because it facilitates food intake but also because it elicits responsive accommodations from the care-taking adult. This interaction of reflex and response is one of many specific interactions that lend themselves to observations from which inferences about mutual adaptation between caretaker and infant can be made.

Other gems in the author's review of research trends deal with the infant's physiologic state as an important determinant of behavior and its relevance for evaluating studies of neonatal response; excitability as a biologic characteristic of infants that differs among infants and may be one of the important determinants of development; the self-generated activities of infants as essential to maturational advances; and the importance of reciprocal exchanges between the infant and the environment, especially the caretaking adult.

Developmental theories

Dr. Escalona's discussions of operant conditioning theory, of Piaget's theory of learning, and of psychoanalytic theory as approaches to the study of phenomena of infancy are clear and succinct and should be extraordinarily helpful to the reader, as will her words of caution about the tendency to equate phenomena that are related but not identical. In respect to the latter point, for example, she reminds us that the psychoanalytic concept of "object relations" has specific connotations that are very different from the definition of "attachment behavior" as used by the psychologists, though the phenomena are related. In these days when a unitary theory of child development is being sought by many research workers and communication between investigators from various theoretical orientations has increased, it is particularly important for clarity to be maintained in relating developmental phenomena to specific theoretical approaches.

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*THE ROOTS OF INDIVIDUALITY: normal patterns of development in infancy. Sibylle K. Escalona. Aldine Publishing Co., 320 West Adams Street, Chicago, Ill. 60606. 1969. 547 pp. $14.75.

Dr. Escalona's concept of the regularity and orderliness of many developmental sequences includes a great deal more than the biological attributes of the species and the structure of the central nervous system. Rejecting the idea that "maturation" can be defined by the "mere unfolding of completely prestructured and internally programed actualization of inherent capacities" (p. 66), she suggests that organismic similarities and common features in the physical and social environment of all infants result in many similar or identical experiences that partly account for the regularity in development among infants.

This is a very condensed way of recognizing the existence of a complex and heterogeneous set of interacting variables that are beyond the knowledge of any one person to encompass. Yet Dr. Escalona, I believe, renders an important service in insisting that investigators view developmental phenomena with these complexities in mind. She reminds her readers a few paragraphs further on that the term *development* "includes not only bodily coordinations and cognitive skills, but also affective experience and the control of impulse, attitudes, and interests, preferred styles of adaptation, and a host of behavior attributes subsumed under such terms as personality, character or temperament." (p. 67.)

Study methods

In subsequent pages the author describes the basic data and methods of data analysis of the specific research project with which most of the book deals. The process of transforming narrative records and written observations into usable research data is described in enough detail to acquaint the reader with the two major uses of the data decided upon: "(1) to describe the phenomenology of normal infant behavior during the first eight months of life and to formulate hypotheses about the relevance of particular behavior activations to ongoing developmental changes; and (2) to explore the possibility that individual differences among normal infants are consistently related to experience patterns that are prominent and stable components of the infant's day-by-day existence." (p. 76.)

In chapter 8, the hypotheses and inferences developed from the comparison of active and inactive infants are presented and discussed, as are some of the observations that led to the hypothesis that the "course of early development tends to follow a different pattern in active and inactive infants." Careful reading and rereading of this material can be of great value, especially to the child development investigator. Not only is the material presented clearly, but also in such a way that the reader is stimulated to ask his own questions.

Patterns of experience

In the last section of the book, Dr. Escalona views the infant's development in the light of stable patterns of experience, since ". . . developmental outcome (rate and pattern of development as well as individual characteristics of adaptive functioning) is directly related to such stable patterns." (p. 253.) This view requires the juxtaposition of assessment of reaction tendencies and assessment of environmental conditions to permit the construction and documentation of the stable patterns of experience. In the process, the author employs a modified version of the constructs developed by Kurt Lewin[1] as a method of systematic description. She outlines and defines eight patterns of experience and rates them for each child in her study.

There follow chapters on the components of the stable patterns of experience (SPE)—structural, dynamic, and developmental outcome—and descriptions of individual children studied according to this system. For most readers, these descriptions will be the most gratifying part of the book because in them the infants come alive even as precision of description is maintained.

In summary, this book is an enormously valuable contribution to the field of child development in general. While it deals with trends and methods of research in infancy, demonstrating the need for complexity in theory and methodology of data collection and analysis, it at the same time contains a rich source of information for all who are interested in child development.

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[1] Lewin, Kurt: Principles of topological psychology. McGraw Hill, New York, N.Y. 1936.

guides and reports

PARENTS AND THE DAY CARE CENTER. Thelma Adair and Esther Echstein. Federation of Protestant Welfare Agencies, 281 Park Avenue South, New York, N.Y. 10010. 1969. 36 pp. $1.50.

Offers suggestions for involving parents in the organization and operations of day-care centers for their children.

THE SEX EDUCATOR AND MORAL VALUES. Isadore Rubin. Sex Information and Education Council of the U.S., 1825 Willow Road, Northfield, Ill. 60093. SIECUS Study Guide No. 10. February 1969. 25 pp. 50 cents.

A guide *for the use of professional persons* helping young people make their own decisions among a "conflicting array of sexual values."

ABOUT DRUGS. Abstracted by Thomas C. Logan. Edited by Carl C. Hug, Jr., John C. Pollard, and Maurice H. Seevers. Orientation Office, University of Michigan, 529 Thompson Street, Ann Arbor, Mich. 48104. 1969. 15 pp. 25 cents.

Directed to young people, particularly college students, this booklet presents information on the effects on mind and body of narcotics, barbituates, stimulants, hallucinogens, marijuana, and alcohol.

ANALYZING COSTS IN A RESIDENTIAL GROUP CARE FACILITY FOR CHILDREN—a step-by-step manual. Robert Elkin and Delroy L. Cornick. Child Welfare League of America, Inc., 44 East 23rd St., New York, N.Y. 10010. 1969. 116 pp. $3.

Presents directions for setting up a "do-it-yourself" cost analysis system in a residential child care facility and for conducting time studies in connection with the analysis.

BOOK NOTES

PIAGET AND KNOWLEDGE: theoretical foundations. Hans G. Furth. Foreward by Jean Piaget. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1969. 270 pp. $7.95.

This book provides a general introduction to Jean Piaget's theory of development of cognitive functions. The author, a psychologist who spent a sabbatical leave from Catholic University with Piaget and associates at the International Center of Genetic Epistemology in Geneva, emphasizes the biological framework that unifies the various facets of the theory and suggests that the theory applies to all areas of human behavior.

Explanations of Piaget's concepts of operative knowing, symbolic knowing, figurative knowing, biology and knowledge, and development and learning are followed by excerpts from Piaget's writings.

In the final chapter, the author summarizes seven themes in Piaget's theory: biological behavioral unit, biological organization, intelligence, operations, formal reflecting abstracting, figurative knowledge and memory, and symbol functioning.

In the foreword, Piaget says that the aim of his research is "to explain the development of intelligence and to comprehend how from elementary forms of cognition superior levels of intelligence and scientific thinking come about."

A TIME TO HEAL: corrective socialization—a treatment approach to childhood schizophrenia. William Goldfarb, Irving Mintz, and Katherine W. Stroock. International Universities Press, Inc., New York, N.Y. 1969. 148 pp. $5.

This book describes a method of "corrective socialization" used at the Ittleson Center for Child Research in New York City to alter erratic behavior of children with schizophrenia in the direction of more normal expression. The authors, who are the director and two staff members at the center, define the center's objective as stimulating "positively and comprehensively" the growth of absent or deficient function in the schizophrenic child by constantly exposing him to a flow of sensitively handled experiences.

The authors report that the center provides a carefully structured physical setting and a time pattern where regularity, routine, and repetition are consistently observed. In describing the residential program which serves 24 children aged 5½ to 11 who have been diagnosed as suffering from childhood schizophrenia, they stress the "processes of human interaction" as the most important method of achieving correction.

Case examples with comments by the authors are presented to illustrate the schizophrenic child's desperate strivings to achieve a sense of himself as distinguished from the nonself, methods of penetrating self-defeating defenses of the child "against the terrifying experience of awareness," and problems of communication. The authors maintain that the "great majority" of schizophrenic children who are free of neurological involvement improve under the center's treatment.

BAYLEY SCALES OF INFANT DEVELOPMENT: manual. Nancy Bayley. The Psychological Corporation, New York, N.Y. 1969. 178 pp. $5.

The author notes in her introduction of this manual that many of the scales for assessing child development currently in use are based upon small samples studied 20 to 40 years ago. To meet the need for scales that incorporate newer knowledge and are based upon improved sampling methods, she has prepared this instrument—a revision and extension of earlier tests of infant development.

More than 10 years of work have gone into these Bayley Scales of Infant Development (BSID), which have been standardized on a sample of 1,262 children of 14 age groups from 2 months through 30 months. They provided the following tripartite basis for developmental assessment of children within these age limits.

1. The Mental Scale (163 items), "designed to assess sensory-perceptual acuities, discrimination, and the ability to respond . . . and memory, learning and problem solving ability." Included in this scale are language development and early evidence of the capacity to generalize and classify.

2. The Motor Scale (81 items), designed to measure control and coordination of the large muscles of the body as well as manipulative skills.

3. The Infant Behavior Record, designed to supplement the formal test data by providing information about various behavioral characteristics of the child.

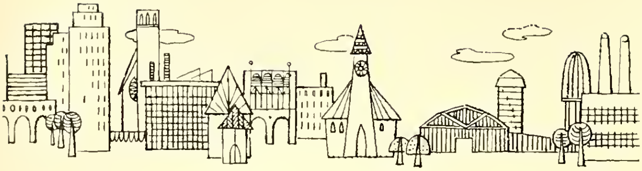
Directions for administration and scoring are included as are details of the standardization process. The author points out that the effective and skilled use of the BSID requires training and personality traits that permit one to work well with very young children.

CHANGING THE FAMILY. Warren M. Brodey, M.D. Clarkson N. Potter, Inc., New York, N.Y. 1968. 160 pp. $6.

The methods of psychotherapy described in this book provide help for a disturbed child by bringing all members of a dysfunctioning family together in sessions with a psychiatrist to work out changes. Dr. Warren M. Brodey says that problems in development of children and adolescents—delinquency, withdrawal, and many others—occur within the environment of the family and therefore, "The whole family is the patient."

Before beginning to help a family, the author explains, the therapist must determine the amount of contact the members experience with one another. He says contact is a means of behavioral evolution that allows the family members "to die and be reborn with each learning, changing *what was* to *what is more viable* in the next context." The author pinpoints some of the devices—words, phrases, complaints, roles, and stage props—that family members use to avoid contact.

HERE and THERE



Child safety

On November 10, 1969, the President signed the Child Protection and Toy Safety Act of 1969 authorizing the Secretary of Health, Education, and Welfare to ban the sale of any toy or other article intended for use by children that presents an electrical, mechanical, or heat hazard. The measure, which amends the Federal Hazardous Substances Act, goes into effect on January 5, 1970.

If, under the 1969 Act, the Secretary finds that a toy or other article presents an "imminent hazard" to public health, he may ban the article, giving notice through the Federal Register. Any person who will be adversely affected by the ruling may petition a U.S. Circuit Court of Appeals within 60 days for a judicial review. The Secretary's ban will stand until proceedings are completed.

The act also provides for a refund of the purchase price to the buyer by the manufacturer, distributor, or retail dealer, including "reasonable and necessary transportation charges" incurred in the article's return.

The act defines the hazards as follows:

- **Electrical hazard.** If, in normal use or when subjected to reasonably foreseeable damage or abuse, the article's design or manufacture may cause personal injury or illness by electric shock.
- **Mechanical hazard.** If, in normal use or when subjected to reasonably foreseeable damage or abuse, the article's design or manufacture presents an unreasonable risk of personal injury or illness (1) from fracture, fragmentation, or disassembly of the article, (2) from propulsion of the article (or any part or accessory thereof), (3) from points or other protrusions, surfaces, edges, openings, or closures, (4) from moving parts, (5) from lack or insufficiency of controls to reduce or stop motion, (6) as a result of self-adhering characteristics of the article, (7) because the article (or any part or accessory thereof) may be aspirated or ingested, (8) because of instability, or (9) because of any other aspect of the article's design or manufacture.
- **Thermal hazard.** If, in normal use or when subjected to reasonably foreseeable damage or abuse, its design or manufacture presents an unreasonable risk of personal injury or illness because of heat, as from heated parts, substances, or surfaces.

Combustible articles (containing any substance that has a flash point above 80°F.) are added to the flammable category of the Federal Hazardous Substances Act.

White House Conference

On October 27, President Nixon issued a statement on the seventh decennial White House Conference on Children and Youth to be held in Washington, D.C., December 13–17, 1970. (See CHILDREN, May–June 1969, p. 121.) At the same time he released a letter to the Governors of each State urging the States' continued cooperation with the conference. On December 5 he named his former deputy assistant for urban affairs, Stephen Hess, to be national chairman of the conference. Joseph H. Douglass, former conference director, has been made chairman of the steering committee of the soon to be named national committee for the conference.

According to the President, the conference will have a three-part emphasis, focusing attention on:

1. Infants and young children, fron birth to age 5 years.

2. Children from the ages of 6 to 14

3. Youth from the ages of 14 to 21

The President pointed out that h was "particularly gratified to know tha the early childhood years, of such vita intellectual and emotional importanc to children," were to be studied an discussed.

In his statement the President expressed the hope that "the States voluntary organizations, professiona groups, Federal departments and agencies, and the general public, includin young people," will work together t make the conference a success.

The new headquarters for the conference are at 400 Sixth Street SW., Washington, D.C. 20201.

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The first completed State report relating to the 1970 White House Conference on Children and Youth wa issued on October 7, 1969, by the Committee on Children and Youth of th Pennsylvania Governor's Council fo Human Services, the committee designated by Governor Raymond P. Schaefer as Pennsylvania's Committee fo the conference. Entitled "For the Hous of Tomorrow," the report is the resul of dialogues between young people an adults and other joint youth-adult activities in every one of the State's 6 counties, involving a total of 2,300 persons. A synthesis of county reports which, according to the introduction "range in sophistication from very complex sociological studies to simple bu forceful statements of problems," i presents many recommendations for action to meet the needs of children an youth, labeling 10 of these as "majo recommendations." In brief they are

1. Lowering the "full legal age" fron 21 to 18.

2. An overhaul of the Selective Service System.

3. Youth representation on all polic and advisory committees concerne with the young.

4. Expansion and modernization o the educational system to improve educational and guidance opportunities fo preschool children, emotionally disturbed children, inner-city children, an nonacademic students and to create fo all "an educational experience that prepares children for life in a rapidl changing world."

5. Increased State support for recrea-onal programs, especially for children nd youth in the cities.

6. Remembrance of the "sad experi-nces of the Volstead Act" in attempt-ng to control the use of nonaddictive rugs.

7. A national commitment to see that ll citizens have decent housing, suffi-ent income, meaningful employment, dequate health services, and equality nder the law.

8. Support for the President's efforts o bring an early end to the war in ietnam.

9. Elimination of racism and "the rowing tendency toward separatism" n American life.

10. A reassessment of the role of eligious institutions in American life.

Preschool education

That attendance at a preschool pro-ram can help disadvantaged children unction better when they reach the rst grade of school is indicated by the ndings of a study recently completed n Ogden City, Utah, by Sheldon L. Cal-ister, former director of psychological ervices for the Ogden City Head Start Program, and Robert D. Eyestone, dis-rict school counselor for the Ogden City school system.

Their study showed that disadvan-taged children who had been enrolled n the local Head Start program before ttending school did better in the first grade on nine measures of achievement than a matched group of children who had not attended a preschool program. While the differences between the two groups were not statistically significant on all nine measures, they were signifi-cant and in favor of the former Head Start children in areas of social devel-opment and academic achievement.

The study involved a comparison of the performance in the first grade of an experimental group of 41 disadvan-taged children who had been enrolled in Head Start with that of a control group of 41 disadvantaged children—matched with the experimental group on the basis of sex, economic background, school, class, and teacher—who had not attended a preschool program. At the end of the academic year, the teachers were asked to rate the children's performance as "poor," "adequate," "good," or "superior" in such areas as verbal communication (amount and quality), self-concept, social development, concept formation, muscular coordination, attention, and achievement in reading and number concepts. The teachers were not told that a comparison of the performance of the groups of children would be made.

Twice as many children in the experimental group (22) as in the control group (11) received high ratings in achievement both in reading and concept formation. The teachers gave high ratings on social development to 24 children in the experimental group, compared with 13 in the control group; on achievement in number concepts, to 23 in the experimental group compared with 13 in the control group; on both amount of verbal communication and self-concept, to 22 in the experimental group compared with 16 in the control group; on quality of verbal communication, to 19 in the experimental group compared with 14 in the control group; on muscular coordination, to 27 in the experimental group compared with 21 in the control group. However, almost as many children in the control group (16) as in the experimental group (17) received high ratings on ability to stick with the ongoing process (attention).

The composite ratings of all nine factors showed a highly significant difference between the two groups in favor of the former Head Start children.

Student volunteers

Undergraduate psychology students with some training in behavior modification therapy helped mentally retarded children in an institution accomplish changes in behavior through a volunteer service program directed by D. Eugene Thorne and Martin Schinedling of the Psychology Department of Brigham Young University, Provo, Utah, during the 1968–69 school year. The program was designed primarily to train students in planning and administering programs to modify behavior through the method of operant conditioning.

For the first 2 weeks of the fall semester, 90 students attended classroom lectures and group discussions on behavior modification therapy at the university, after which they formed nine teams of 10 members each. This was followed by 2 weeks in orientation sessions at the institution. Each team was then assigned to a child selected by the institutional staff on the basis of a manifested behavior problem considered to be amenable to change.

Working in pairs, the students observed the child's behavior and the conditions under which the behavior problem occurred. They then designed a plan for intervention, which they carried out during the next 10 weeks under the supervision of the program's directors and the institutional staff. At the end of the semester, the student teams evaluated their work with the children—whether they had been successful in eliminating the problem behavior or establishing new forms of behavior—and made recommendations for the staff and for future student teams.

Student teams worked with nine children, having 12 types of behavior problems—among them, self-mutilation, biting other children, failure to answer when called, tearing sheets, violent tantrums, failure to learn to read and to feed oneself, and nonverbalization. The children ranged in age from 7 to 20 and had IQ's ranging from 6 to 39.

The teams were successful in establishing six new forms of behavior in six of the nine children, including three children with whom previous efforts had failed. One child learned to respond to people when called, one was able to learn the alphabet and to read, one learned to make his bed, one became able to feed himself, and one started to talk. In bringing about behavioral changes, the students used a combination of attention and approval, along with material rewards such as palatable foods, money, or tokens. All attempts to eliminate certain types of behavior problems failed. The directors of the program are therefore recommending that, in similar programs, emphasis be placed on selecting forms of behavior to be established rather than eliminated.

Foster care

No one pattern of child welfare services is consistently available in this country's urban areas, nor is there a generally accepted concept of what services should be available, according to the recently issued report of a study of foster care needs in seven U.S. cities, carried out by the Child Welfare League of America, with a Federal grant from the Children's Bureau. The study was intended to learn the actual need of foster care in the seven cities on the basis of actual requests for care, but the findings showed that requests varied according to the services available.

A total of 69 voluntary and public agencies participated in the study, which covered a 3-month period in 1966. These agencies reported receiving 1,488 requests for care during the period, not counting requests coming from outside their service areas. Detailed information on the child, his family, and the outcome of the request was received in regard to 1,260 of these requests.

The primary reasons prompting the requests were reported as the behavior of the parent toward the child (308); birth out of wedlock (307); the child's behavior (199); psychosocial stress (193); parental incapacity (148); socioeconomic stress (129); pregnancy out of wedlock (102); child's incapacity (26); and unclassified (76).

The study found that in many instances racial and economic factors were associated with the type of decision made for the child: relatively fewer nonwhite infants were placed for adoption, and girls placed in maternity homes tended to come from families of higher incomes, as did children placed in specialized institutions.

The study also found that, in the opinion of the agencies' caseworkers, many of the requests for foster care would not have been made if adequate economic support and social services had been made available to the families earlier.

A detailed report of the study, "The Need for Foster Care: An Incidence Study of Requests for Foster Care and Agency Response in Seven Metropolitan Areas," is available from the Child Welfare League of America, 44 East 23rd Street, New York, N.Y. 10010. (Price: $3.)

Screening tests

Applying screening procedures to high-risk groups of children is a more efficient method of detecting inborn errors of metabolism than screening the entire pediatric patient load of a hospital, according to the findings of a study carried out in the 3 years ending June 30, 1968, at the Children's Hospital Medical Center of Boston, Mass., with support from the Children's Bureau. Under the direction of P. S. Gerald, M.D., the study involved comparison of the results of screening of all pediatric patients of the hospital for 1 year with the results of applying screening procedures only to neurological patients or other patients showing specified symptoms, such as mental retardation, nephritis, seizures, or peculiar feces. Urine and blood tests were used in both parts of the study.

In the first phase of the study, transient blood and urine changes were found in many children, but few diagnoses of inborn errors of metabolism resulted. The arduous task of separating the meaningful changes from the numerous "false positives" led the investigator to conclude that the screening procedures were economically impractical. He attributed the transient changes to antibiotic therapy or the temporary metabolic derangement of acute illness.

The second phase of the study, however—the screening of high-risk patients—resulted in definitive diagnoses of disorders resulting from defective amino acid metabolism in 13 children in whom such disorders had not previously been diagnosed. Dr. Gerald has pointed out, however, that while screening high-risk groups results in a higher yield of abnormal findings, the disease process is usually so well underway by the time symptoms have developed that the potential effectiveness of ameliorative therapy has already been reduced.

In another part of the study, 2,400 apparently normal newborns and nearly 600 congenitally malformed children were tested for chromosome aberrations. Twelve (or 0.5 percent) of the apparently normal newborns showed major chromosome aberrations. About 1 percent of the malformed children had chromosome defects that were not clinically recognizable.

• • •

After screening 27,000 newborns for galactosemia, Morris London, Ph. D. of the North Shore Hospital at Manhasset, N.Y., has concluded that generalized screening for this inborn error of metabolism is uneconomical and should not be done except in conjunction with screening tests for other diseases. The study, carried out with support from the Children's Bureau over a 31-month period ending December 9, 1968, ran 40,316 tests on newborn babies at 12 area hospitals, using the same blood drawn for State-required phenylketonuria tests. The same blood was also tested
for Glucose-G-Phosphate Dehydrogeno
(G6PD) deficiency.

Because some of the galactose C
used for testing for galactosemia w
found to be contaminated, only 27,0
of the tests were regarded as valid.
these, seven showed suspicious resul
but none proved to have galactosemi

Of the 40,316 babies from who
blood was taken, 519 were found to
deficient in G6PD. Followup with ph
sicians caring for the babies produc
no evidence that this deficiency caus
disease conditions other than sensitivi
to drugs, according to the investigato

Family planning

All family planning programs of t
Department of Health, Education, a
Welfare have been consolidated in
National Center for Family Planni
Services, established by Secretary Ro
ert H. Finch on October 23, 1969. T
center will function as a clearinghou
for the collection, organization, and di
semination of information on fami
planning. Operating as a part of t
Health Services and Mental Health A
ministration, it will develop new fami
planning programs within HEW a
award grants and contracts for fami
planning services and research. A re
resentative of the Family Planni
Center will be assigned to each
HEW's 10 regional offices.

Against rubella

A $25.6 million program to contr
rubella (German measles) by immuni
ing 60 million children within the next
years is underway in 45 States, the Vi
gin Islands, Puerto Rico, the Distri
of Columbia, and 20 large cities a
counties.

The National Communicable Disea
Center (NCDC) of the Health Servic
and Mental Health Administratio
Public Health Service, is directing t
nationwide program against the diseas
which causes a relatively mild illness
children but may cause severe defects
death in fetuses of women who contra
the disease during pregnancy.

The Federal program was launch
after a vaccine grown in duck embr
was licensed in June 1969. (See CHI
DREN, July–August 1969, p. 166.)
early November 1.2 million doses of th
vaccine had been distributed by t
NCDC to State and local health depar

nts, which administer the vaccine thout charge. Some local programs e designed to immunize elementary ool children during the first phase; se programs will be broadened in the ure to immunize children between age of 1 year and puberty.

At the end of November all but five ates—Indiana, Michigan, Nevada, nnessee, and Washington—had taken ps to enter the Federal rubella con- ol program on a statewide basis. With exception of Washington, these ates have local programs.

iscellaneous

Mexican-American high school stu- nts in Los Angeles, Calif., selected potential school dropouts are learn- g to tutor elementary school students an effort to motivate them to remain school and eventually become achers. This project is one of 700 ing conducted to develop new ways of recruiting, training, or retraining educational personnel through grants from the U.S. Office of Education under the Education Professions Development Act of 1967.

Many of the projects are designed for persons who have in the past been considered unqualified to work in schools. For example, 12 former drug addicts are being trained as student counselors in Mendocino County, Calif., in the hope of reducing drug use by high school students.

• • •

A film guide on reproduction and development has been issued by the National Institute of Child Health and Human Development (NICHD), National Institutes of Health, Bethesda, Md. Designed to be used in teaching and research settings in colleges, universities, and graduate schools, the guide describes 26 films selected for their significance, general interest, theoretical importance, stimulation of new ideas, clarity, effectiveness, photographic quality, and accuracy.

The guide was developed by the Mental Health Materials Center in New York City under a contract with NICHD. The center catalogued 596 film titles, from which the scientists selected 170 for screening and review.

The films are grouped under six main topics: (1) structure and function of cells, (2) mitosis and meiosis, (3) development of invertebrata, osteichthyes, and amphibia, (4) differentiation and organogenesis, (5) courtship and reproduction, and (6) techniques. Each entry contains a description of the film's contents, notes on audience suitability, where and how obtainable, year produced, whether sound and color, running time, and the scientists' evaluation of its usefulness.

Single copies are free from the Public Information Office, NICHD, National Institutes of Health, Bethesda, Md. 20014.

IN THE JOURNALS

ead Start children

Many children in Head Start pro- rams may be "oversocialized," or able o cope with matters of self-care, com- unication, and cooperation with thers at a level beyond their under- tanding, reports Frances J. Norton in he November 1969 issue of *Exceptional Children*. ("Oversocialization of the Young Culturally Deprived Child.") The author, chairman of the psychology department at Guilford College, Greensboro, N.C., and psychological consultant for a local Head Start program, points out that below average social ages "would have been predicted" for many of the children who had come from conditions of social isolation, cultural deprivation, personal neglect, or some combination of these and whose intelligence scores were below average. However, she reports, interviews with 99 disadvantaged Head Start children revealed that their social maturity was, on the average, 0.2 years in advance of their chronological age.

The author reports that, in addition to interviews with parents and teachers, the Vineland Maturity Scale was used to appraise social ages and the Harris-Goodenough Draw-A-Man Test was used to appraise mental ability. Of the 48 children with estimated IQ scores below 90, 54 percent had social maturity scores equal to or above their chronological ages.

In the Head Start classroom, says the author, the children appeared to be living in a "highly familiar environment" for which they had ready responses, although the environment was new and often extremely different from their home environment. She suggests that since these children had not previously been in school, their social maturity must be reflecting the experiences and demands of the home situation.

The author regards the "oversocialized" children as "striving mightily to meet the demands of an adult world." She suggests that many of these children need freedom for self-determination and self-discovery as well as "experience with adults as sources of affection, assistance, and understanding rather than as sources of information and new ideas."

Flexibility in casework

Before they call disadvantaged families "unmotivated" and therefore "untreatable," social workers should "take a hard look" to see whether their traditional casework techniques are not too rigid, suggests Dorcas D. Bowles, a social work supervisor at Chicago's Institute of Juvenile Research, in the October 1969 issue of *Child Welfare*. ("Making Casework Relevant to Black People: Approaches, Techniques, Theoretical Implications.")

Drawing on her experience in working with mothers and preschool children in a large public housing project in a black urban neighborhood, the author points out that there is wide variety among the poor in childrearing practices and philosophies, family organizations, functioning levels, interpersonal styles, values and goals, interests, talents, and potentialities. She adds, however, that most disadvantaged and disorganized families share a characteristic sense of helpless resignation in dealing with persons associated with power structures.

Maintaining that to help such families the caseworker must become "involved in their lives," the author suggests 13 "special techniques" for doing so. Among these are:

- A casualness and down-to-earth approach to the mother.
- Use of familiar language without "talking down."
- Showing the mother her own area of competence.
- Demonstrating in both words and action how a situation can be handled—especially in dealing with children.
- Using toys and projects to give mother and child experiences of success.
- Flexibility in timing and place of interviews.
- Involving mothers in social action to help them acquire a sense of power.
- Seeing oneself as a "giving human being" first, and as a caseworker second.

Out-of-wedlock births

A uniform method for determining an "incidence rate" of repeated out-of-wedlock births among adolescent girls is suggested by John J. Dempsey in the October 1969 issue of *Public Health Reports.* ("Proposed Standard Measure of Recurrence of Out-of-Wedlock Births to Adolescents.") The author, an assistant professor at the School of Hygiene and Public Health, Johns Hopkins University, says that followup studies of programs serving adolescents during a first out-of-wedlock pregnancy have found "without exception an alarmingly high recurrence rate."

After reviewing the literature for five followup studies of repeated out-of-wedlock births among adolescent unmarried mothers, Dr. Dempsey reports that the basic units of measure were not "even remotely comparable." He presents a table showing that one study that followed girls for 18 months after delivery of a first out-of-wedlock child found a recurrence rate of 19 out-of-wedlock deliveries for each 100 girls at risk; another study covering a 5-year followup period found a recurrence rate of 95 out-of-wedlock deliveries for each 100 girls at risk.

The author proposes "a basic, flexible, conventional recurrence rate" that can be accepted by independent researchers to generate comparable data. The rate would be determined from the following figures:

Denominator: Number of out-of-wedlock deliveries in the original service population, excluding girls lost to followup studies or those who marry before the recurrent event.

Numerator: Number of repeat out-of-wedlock deliveries among the same basic population.

Unit of time: A 24-month followup after the first delivery.

Continuity of care

"The decision to remove a child from his home is an extremely important one but the decision as to where to place a youngster is equally important," says Cameron L. Clemens, superintendent of the North Dakota Industrial School, in the October 1969 issue of the quarterly, *Public Welfare.* ("Continuity Through Lasting Parentship.") Using the term "parentship" to denote the substitute parental guardianship provided by community agencies, he emphasizes the importance of "consistent parentship" throughout the entire treatment process for children who have been separated from their parents because of behavior problems.

Pointing out that communities today are better prepared "with improved agency programs, both in quantity and quality than at any other time," the author maintains that they have not kept abreast in ability to distinguish the specific service best suited for the individual child. One result, he says, is that institutions for delinquents are today seeing youngsters who, because of previous exposure to a variety of child-care settings and agency parentships, are much more sophisticated than those who came to institutions in the past in "how to behave and what to say without undergoing any basic personality change."

The author recommends that the community agents responsible for removal of a child from his home plan for provision of adequate and consiste parentship *before* seeking out a trea ment program. Such planning, he poin out, will require evaluation of prese administrative structures and commi ment procedures.

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collected readings

READINGS IN COMMUNITY ORGA NIZATION PRACTICE. Edited b Ralph M. Kramer and Harry Spech Prentice-Hall, Inc., Englewood Cliff N.J. 07632. 1969. 458 pp. $5.95.

ANNUAL PROGRESS IN CHILD PSY CHIATRY AND CHILD DEVELOP MENT. Edited by Stella Chess, M.D and Alexander Thomas, M.D. Brun ner/Mazel, Inc., 80 East 11th Street New York, N.Y. 10003. 1969. 565 pp $15.

LEARNING DISABILITIES: introduc tion to educational and medical man agement. Compiled and edited b Lester Tarnopol. Charles C Thomas 301–327 East Lawrence Avenue Springfield, Ill. 62703. 1969. 389 pp $16.75.

THE MULTIPLY HANDICAPPED CHILD. James M. Wolf and Robert M. Anderson. Charles C Thomas. 301–327 East Lawrence Avenue, Springfield, Ill. 62703. 1969. 468 pp. $21.

THEORIES AND METHODS OF GROUP COUNSELING IN THE SCHOOLS. George M. Gazda, Charles C Thomas, 301–327 East Lawrence Avenue, Springfield, Ill. 62703. 1969. 220 pp. $7.50.

SOCIAL WELFARE AND HUMAN RIGHTS. Columbia University Press, 440 West 110th Street, New York, N.Y. 10025, for the International Council on Social Welfare. 1969. 398 pp. $10, clothbound; $6, paperback.

SOCIAL WORK WITH GROUPS. Helen Northen. Columbia University Press, 440 West 110th Street, New York, N.Y. 10025. 1969. 270 pp. $7.50.

READERS' EXCHANGE

DAYTON: *Complex problems*

In his article, "Malnutrition and Human Development", Delbert H. Dayton provides an excellent analysis of the present status of this important problem. (CHILDREN, November–December 1969.) Drawing from selected references and his own considerable personal experience, he has summarized pertinent information on the subject, ranging from changes in the DNA and protein content of brain cells to the clinical aspects of limitations in individual capabilities and performance.

The content of Dr. Dayton's presentation is drawn almost entirely from studies conducted outside the United States during the past 10 years—a reflection of the fact that concern until recently has been primarily in developing countries. However, as Dr. Dayton points out, during the past few years Schaefer and associates of the Public Health Service and Owen and associates for the Children's Bureau have undertaken extensive studies of the status of nutrition in the United States with findings that indicate an appreciable incidence of malnutrition in the low-income groups. The significance of these observations has been greatly amplified by the Senate Select Committee on Nutrition and Human Needs and the White House Conference on Food, Nutrition and Health.

Important problems of diagnosis, incidence, degree of severity, therapy, and prophylactic measures all call for solution. However, as Dr. Dayton indicates, much of the information that is needed for solving these problems and developing policies of action is not available as yet. It is, therefore, necessary to develop public health programs within the framework of our present knowledge to improve the general well-being and particularly the nutritional status of populations at risk. It is also imperative that well-designed multidiscipline research programs be supported and appropriate new ones encouraged, both in the United States and abroad, so that more definitive information can be obtained.

In this manner, we can begin to deal with the existing situation and to develop realistic guidelines for the future management of the problem of malnutrition as it affects brain function and the complex interrelationships of individual, family, community, and nation that are involved.

David Baird Coursin, M.D.
Director of Research
Research Institute
St. Joseph Hospital
Lancaster, Pa.

An ecological approach

Though being obliged to draw upon research data collected in developing countries for his article in CHILDREN, Delbert Dayton has focused our attention on the need for a method of systematic collection of dietary data when dealing with impoverished population groups in the United States.

Presently any marked variation in growth from an accepted standard suggests that an evaluation of nutrient intake is appropriate. Dr. Dayton points out that small size per se is not what matters to the health of the child, but what may go with it—possible changes in metabolic pathways, body composition, and ultimate functional ability. He substantiates this concept by references to studies suggesting that malnutrition in early life can interfere with cell division and so result in fewer cells. This appears to be a permanent effect.

Dr. Dayton also presents an important concept when he points out that it is necessary to distinguish between an acute, sudden onset of malnutrition in expectant mothers and the kind of chronic malnutrition that exists in developing countries.

Traditionally nutritionists have placed much faith in the outcome of biochemical determinations, especially in population surveys, but Dr. Dayton explains that such determinations are incapable of identifying protein deficiency in an individual child until shortly before the onset of overt kwashiorkor. He also points out that clinical signs of malnutrition may not occur in preschool children with sufficient frequency to be of great value in determining the nutritional status of a preschool population.

Dr. Dayton has provided an excellent ecological approach to the problem of early malnutrition and human development, by bringing together important variables in the biological, physical, and psychological environments that affect growth and development.

Virginia A. Campbell
Chief Nutritionist
Child Development and
Mental Retardation Center
University of Washington

BRIELAND: *An irrelevant question*

In his article, "Black Identity and the Helping Person" (CHILDREN, September–October 1969), Donald Brieland correctly concludes from the data that low-income blacks prefer black service-givers over white service-givers if they have a choice (which they often don't). He further states, "This study does *not* (italics his) show that white helping persons are unwelcome in black neighborhoods." Since the study did not deal with this issue, one could say with equal validity that the study does not show that white helping persons are welcome in black neighborhoods. Denying the negative does not affirm the positive.

The data regarding one question—"Would it make a difference in your choice if a white person were better qualified?"—seems to indicate that lower-class blacks would consistently choose the better qualified white service-givers over less qualified black service-givers. From a practical standpoint, however, this question is irrelevant. Lower-class blacks do not know the criteria nor do they have the necessary information to compare one professional person's qualifications with another's.

One recent study has indicated that 35 percent of the blacks interviewed approved the stand taken by Stokely Carmichael, who advocated separation to obtain higher social and economic status. Would white service-givers be welcomed by this group of ghetto residents? (National Advisory Commmission on Civil Disorders. *Supplementary Studies.* Washington, D.C.: U.S. Government Printing Office, 1968. Also see John B. Turner, Sumati N. Dubey, and Magdalena Miranda, "Black Unity and Self-Determination: Social Welfare Implication," School of Applied Social Sciences, Case Western Reserve University, Cleveland, Ohio, 1969. (In press.)

"Liberal" whites may find such trends painful to acknowledge, but it may be that blacks need to build up their self-esteem from within before turning outward to whites who have often predicted their failure and set the conditions conducive to that end.

Jack B. Joelson
School of Applied Social Sciences
Case Western Reserve University
Cleveland, Ohio

MEYER: *Freedom of choice*

Margrit Meyer's "Family Ties and the Institutional Child" (CHILDREN, November-December 1969) made me recall, by contrast, an era when a major emphasis in institutional treatment was separating a child from the pathology of his home. The concept of separation is still valid, but we have learned that the child really has to separate himself, in his own way, at his own rate. The social worker cannot be a fairy godmother who rescues the child from his cruel family.

Revealingly, in one of Professor Meyer's case illustrations, when the institution became convinced of the need to locate parents who had long been missing, it located them.

Cunningham Children's Home has had the experience of developing successful foster home ties for disturbed children, many of whom had histories of foster home failure. One of the techniques employed is "Every eventual foster home placement begins with a visiting relationship."

Many of us are aware that the wall between institution and life in the community, with or without family ties, is too formidable. There is constant tension between two poles: the therapeutic community, designed to permit growth away from family; and the child's family or community toward which he strives. Professor Meyer indicated that the tension between these poles can be relieved by gradual exposure to a family on a carefully planned basis. The child in the institution can, in this way, still retain freedom of choice about the degree of his investment in family.

Paul Steinfeld
Director
Pleasantville Cottage School
Jewish Child Care Association
of New York, Pleasantville, N.Y.

Perpetuating dependence

In her article, "Family Ties and the Institutional Child," Margrit Meyer presents what seems to be a pessimistic view of children's ability to develop an increasing variety of meaningful relationships after natural family ties have been broken. She is therefore inclined to rely on the use of the child-caring institution for on-going dependence and security.

From my own experience in the residential treatment of emotionally disturbed youth, I know that many young people have developed meaningful treatment relationships which have contributed to the development of ever-widening circles of relationships, self-dependence, and increasing maturity. Therefore I would resist perpetuating institutional ties whenever other opportunities would be at all possible.

I agree with Miss Meyer's concern for analysis of family ties and for establishing substitutes for the natural family when appropriate. Some type of responsible guardianship must be provided when parents cannot care for their children. I believe an agency that provides services to families in their own homes, rather than the treatment institution, would more appropriately be the responsible guardian.

Although I might argue with Miss Meyer in regard to methods, I hope we agree that our basic conviction is to provide individualized planning and service to the young people for whom we have professional responsibility.

A. M. Banker
Executive Director
Lutheran Children's Home
Waverly, Iowa

Continuing to care

I must say that as I read Miss Meyer's article, "Family Ties and the Institutional Child," my wish was that an Aladdin's lamp would produce more institutions like it and they would be located in Maryland. While we are fortunate to have institutions in Maryland with "caring" leadership, they are becoming fewer.

On reading this article I wondere whether some child welfare worker would say to themselves, "We alread know this." But do we? Are we actuall involving the family and the child i our treatment as is done at Cunningham

Miss Meyer's treatment of the worke in the section on continuing relationships especially interests me. For children who have not formed relationships with other people, the Cunningham staff plans ways of meeting this need. Cunningham also stresses the importance to the child of a continuing relationship with a person who has played a significant role in his life in enabling him to carry on such a relationship.

When the child or the worker leaves the agency, the worker may feel a responsibility to continue. To be caring and to be concerned are two qualities we hear much about today in our work with families who are deprived in many ways. The caseworker who has these qualities, sufficient strength to continue, and an understanding of the implications of doing so can help the child to change in important ways.

One issue that has been on my mind since reading the article is how to relate these methods and principles to the provision of social services to families on public assistance. If in the provisions of social services to families in the AFDC program, we can produce workers who help by consistently demonstrating interest and concern, we can decrease those situations where children are hurt so much that they cannot remain in the home.

Virginia Richardson
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and Child Welfare Services
Maryland State Department
of Social Services, Baltimore

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EW refers to Department of Health, Education, and Welfare; SRS, to Social and habilitation Service; PHS, to Public Health Service; NIH, to National Institutes Health; OCD, to Office of Child Development.

ESEARCH RELATING TO CHILDREN: bulletin no. 24 (September 1968–March 1969). HEW, SRS, Children's Bureau. 1969. 143 pp. $1.50.

Includes brief reports on current and cently completed research reported to e Clearinghouse for Research in Child fe between September 1968 and arch 1969, in such areas as growth d development; personality and adstment; handicapped children; family lations and child-rearing; socioecomic and cultural factors affecting ildren; educational processes; and so l and health services.

RELUDE TO SCHOOL: an evaluation of an inner-city preschool program. Ivor Kraft, Jean Fuschillo, and Elizabeth Herzog. HEW, SRS, Children's Bureau. CB Research Reports No. 3. 1968. 92 pp. $1.

Describes the accomplishments in tellectual functioning made by 3-ear-old children from a slum area Washington, D.C., during the 2 ears they were enrolled in an experi- ental nursery school under a pre- hool project at Howard University, egun before the advent of Head Start. he project, which also included work ith the children's parents, was designed to find out whether such a preschool experience would enhance the children's later achievement in school. (See CHILDREN, July-August 1968, pp. 135–143.)

HIGHLIGHTS OF RESEARCH PROGRESS IN HUMAN DEVELOPMENT. HEW, PHS, NIH, National Institute of Child Health and Human Development. 1969. 11 pp. Single copies free from the Institute.

Contains brief statements on the progress of research being conducted or supported by the National Institute of Child Health and Human Development in the areas of population, reproductive biology, perinatal biology, child development, physical development, mental retardation, and the aging process.

GUIDES ON FEDERAL REGULATIONS GOVERNING SERVICE PROGRAMS FOR FAMILIES AND CHILDREN: TITLE IV, PARTS A AND B, SOCIAL SECURITY ACT. HEW, SRS, Children's Bureau. 1969. 48 pp. Single copies free from OCD.

Explains the purpose, scope, and meaning of Federal regulations for State programs of services for families and children under title IV, parts A and B, of the Social Security Act—specifically the programs of aid to families with dependent children and child welfare services.

WHO WILL TAKE CARE OF YOUR CHILD WHEN YOU ARE IN TRAINING OR ON THE JOB? HEW, SRS, Children's Bureau. CB Publication No. 467. 1969. 12 pp. 15 cents.

Provides working mothers or mothers in training some advice on choosing a day-care plan for their children and continuing to give their children who are in day care a sense of importance in the family.

CHILD WELFARE TRAINING GRANT AWARDS: fiscal year 1969. HEW, SRS, Children's Bureau. 1969. 12 pp. Single copies free from SRS, Community Services Administration.

Lists, by State, the institutions of higher learning that were awarded teaching grants, traineeships, and short-term training grants during fiscal year 1969 under the child welfare training grant program. Includes tables showing amounts and percentages of grant awards under the program for fiscal years 1964 through 1969.

EAT WELL FOR YOU AND YOUR BABY WHO IS ON THE WAY. HEW, SRS, Children's Bureau. 1969. 4 pp. 10 cents.

Suggests the kinds of food that should be included in a woman's diet during pregnancy.

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children

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THE PROFESSIONS SERVING CHILDREN

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children

Teaching Roles in Preschools

Youth on the Generation Gap

Youth as Advisers to Adults

Helping a Fatally Ill Child

VOLUME 17 • NUMBER 2 • MARCH–APRIL 1970

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Becoming acquainted with solid food, this baby seems a bit surprised. Most pediatricians recommend supplementing babies' milk diets with cereals beginning at 6 weeks to 3 months of age; and the recent White House Conference on Food, Nutrition, and Health recommended that such foods be fortified with iron to prevent iron-deficiency anemia. Highlights from the conference, with some of the major recommendations, are presented in the article beginning on page 69.

Prescott and Jones studied 104 teachers in Los Angeles centers, as well as the children in their care.[10] The children's behavior was rated on a 5-point scale according to level of interest and involvement in their activities. The results indicate that children's level of interest and involvement is high "when teachers behave in certain specific ways." The researchers report:

> **Positive responses from children are highly related to encouragement. They are also related to teacher emphasis on verbal skills, and to lessons in consideration and creativity and pleasure, awe and wonder. They are negatively related to restriction, guidance, and lessons in control and restraint and rules of social living.**

Thus some evidence is emerging to support the proposition that the instructional model, both in its academic and intellectual variants, can be performed with warmth and can carry a therapeutic effect for children needing it. However, more empirical studies of teacher behavior and its effects on children are urgently needed before any teacher role model can justifiably be denounced. Reports emanating from the modern British infant schools suggest that the instructional model, with a strong intellectual emphasis, can be performed in such a way that teachers maintain great respect for and enjoyment of children. Respect and enjoyment seem to be elements of teaching style.

Perhaps one of the most serious problems with the now popular instructional role model is that the role is easily "packaged" and "sold," but that the all-important style elements—such as flexibility, warmth, enjoyment, and encouragement—are neglected. They are aspects of teaching not easily "packaged." There is some evidence that such neglect of style can have deleterious effects on children.[10, 24]

Of course, the roles and styles of teaching are not the only determinants of the outcomes of preschool education. Size of center as measured by the number of children served, type of sponsorship, and the quality and quantity of physical space and equipment are important factors in determining what the teachers and children do.[10] Climate too is a factor. The same teachers vary significantly in their behavior in winter and spring.[25]

Another aspect of preschool centers that has not been studied in relation to its effect on children is the distribution of decision-making authority. An example of this came up during a recent visit I made to a Head Start day care center in the midwest. I sat down to have lunch with the children at the center. The children were very friendly, and the food w very good.

"What is this red stuff we're eating?" I asked t little boy next to me.

"Jello," he answered.

"Where did it come from?" I asked.

"Out there," he said, pointing in the direction the kitchen.

"Where do the people out there get it?"

"From the tree."

"What kind of a tree?"

"A jello tree."

"Have you ever seen a jello tree?"

"Uh huh."

"Where did you see a jello tree?"

"Downtown," he answered.

"On T.V.," said another boy at the table.

"On a apple tree," said another.

Later I suggested to the young teacher that t children might be included in preparing their foo some could stir, some could watch, or taste, or mea ure, and so forth. The teacher replied, "You talk the cook."

As it turned out, the cook was an awesome wom She had a territory, her own area of command, a *nobody* was allowed in that territory, certainly r dirty little boys with dirty little hands! (She w unaware that the State health regulations were her side.) The teachers were afraid to cross h Until it was suggested to them, they did not real that jello could be prepared in the classroom. I sure they have been making jello with the childr ever since!

My friends with elementary school backgroun tell me that janitors have a similar sense of autonor which sometimes conflicts with the elementary cla room teachers' authority.

Teachers and parents

This brings me to the third problem associat with the instructional role model: the relationshi between teachers and their clients.

Whenever I ask a group of preschool teach "Who is your client?," the response is invarial "the child." This seems reasonable, since the ch is the direct recipient of the teachers' services. B like people in other professional roles, teachers ha many different clients. They include the parents, t children, the school board, and the community. seems to me the primary client is really the pare

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Nursery school teachers have long emphasized the ilding of close relationships with parents, and on e whole, they have worked with parents who were eptive to their views on preschool education. But lay the differences between the expectations of rents and preschool teachers constitute one of the ost serious issues facing the profession of pre- hool education.

Many nursery school teachers, especially those who re in the field of nursery education before Head art, have a sophisticated and complex view of the ture of learning and development. Some actively to help parents see the soundness of their views, thods, techniques, styles, and goals in working th young children. They talk of children's learn- g through play, through self-selected activities, ative activities, exploration, and experimentation. ey make complex assumptions about the psycho- namics of growth and development, and the mean- g of children's behavior.

Many parents find it hard to understand the con- pts behind the teachers' methods and so they com- in when they see children "just playing" in the ssroom. Preschool teachers are under great pres- re—sometimes open, sometimes indirect—to pre- re children for school. They are responsible to rents who seek some tangible evidence that they e in fact preparing children for the role of pupil. ldwell has pointed out that "mothers are looking r professional leadership to design and provide ild-care facilities that help prepare their children r today's achievement oriented culture."[18] Many rents are expecting teachers to perform a kind of cher role and adopt a kind of teaching style that e teachers do not like.

In my review of research I found no systematic dy of the conflicting expectations of parents and chers in Head Start. However, I did run across me informal reports of such problems. In an ex- nsive survey of summer Head Start programs in Massachusetts in 1965, Curwood reported on the basis of interviews with parents that "most of the (Head Start) programs, even with a minimal child development emphasis, failed to meet the parents' expectations for more formal education."[26]

In another study, Wolff asked teachers and parents to suggest improvements in the Head Start curriculum.[27] The teachers listed such items as "more materials, more time on emotional and social development" while the parents suggested "more teaching, more work including ABC's and numbers." Similar problems are brought out in Polly Greenberg's sensitive and moving account of Head Start in Mississippi:[28]

> We had to interpret parents' insistence on having children learn ABC's to mean they were insisting that the children learn *reading*. . . . If CDGM [Child Development Group of Mississippi] planners were going to claim to be deeply concerned with community values and parents' ideas, we could not stoically resist parental convictions that reading is critically important.

Sieber and Wilder[29] studied the teacher role preferences of the teachers and parents of first, fifth, and 10th grade children in regard to four basic role models: content oriented; control oriented; discovery oriented; and sympathy oriented. In brief, they found that the younger the child, the more the mother is likely to prefer a "control oriented" teacher, and that this is especially true of the mothers from "working class" families. Only 36 percent of the mothers interviewed preferred the "discovery oriented" teacher role, but 56 percent of the teachers interviewed identified themselves with this model. Moreover, 69 percent of the mothers differed with their children's teachers in their preference of teacher role models. The researchers suggest that as the participation of parents increases in the schools, the level of dissatisfaction will also increase.

Unfortunately, no study of this kind has been carried out with Head Start teachers and parents. However, I would hazard a guess that the disagreement between the teachers' and the mothers' preferred teacher role in Head Start would reach about 80 percent.

Implications for the future

The first impression gained from our current, but limited, knowledge is that the role models to which teachers are committed may not be as important to their effectiveness with children as their individual women, many of them parents of children in the Head Start centers; 31 percent are heads of families. Most of them have only meager family incomes, so meager that in many instances they are supplemented by public assistance. More than half of all trainees are members of minority groups, among which Negroes predominate. The average age of the trainees is just under 36. The average number of children in their families is five.

The trainees usually work a full day in the Head Start program and take their courses one or two evenings a week or on Saturdays. Most of them take 6 hours of credit per term but some take as many as 9 hours. More than 55 percent have been out of school more than 10 years, and more than 27.9 percent have been out of school more than 20 years. Most of them, before entering the program, had not completed high school. On the surface, this would not appear to be a very promising freshman class.

Yet some studies made at participating institutions indicate that trainees in many of the Supplementary Training programs are earning a higher grade point average than the training institutions' regular freshmen. At both South Western Louisiana State College and Becone College in Oklahoma, for example, the HSST trainees scored several tenths of 1 percent higher than the entering freshmen. Similar studies are being made at other participating institutions. In addition, the University of Colorado and Educational Projects, Inc., are jointly conducting a study of the variables associated with trainee success in the HSST program.

The academic dropout rate among trainees has thus far been only 1.2 percent; an additional 8.3 percent of the trainees have withdrawn from the program for personal or family reasons, although in the opinion of the instructor, they were passing the course at the time of withdrawal. Even if the "social withdrawals" were counted in the dropou rate, it would still be below 10 percent—a signif cantly lower rate than the dropout rate in the fresh man year of most colleges.

Under the Head Start Supplementary Training program, these Head Start employees enroll in college courses to earn degrees.

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The program

The training program is offered through 29 institutions of higher education, sometimes on a co lege campus, sometimes in facilities nearer the neigh borhoods where the trainees live and work. While th courses are college level courses usually taught b members of the institution's regular faculty, the cur riculum is not the standard academic curriculum, bu is designated to be closely related to the work i which the trainees are engaged.

To reduce the competitiveness of the college class room and to enhance individual development durin the first year of training, Head Start Supplementar Training courses are given in cluster or contrac classes held specifically for Head Start trainees. Thi has offered two advantages: By attending classe with their peers, the trainees gain confidence in thei ability to do college work; and the faculty gain experience in teaching content material of particula relevance to the Head Start center. After the firs year the trainees generally leave the contract course and enter regular university classes as a direct resul of their newly gained confidence and their experienc with theory as well as practice in early childhoo education and related areas.

All institutions participating in the program hav agreed to—

1. Revise admission policies so that the studen who has not graduated from high school or who doe not have a high school equivalency diploma can en roll for college level courses. Credit for a trainee's work, however, may be held in escrow until he completes work for a General Equivalency Diploma

GED), earns a high school diploma, or completes 2 to 15 semester hours of credit with a grade C verage.

2. Waive admissions tests such as the College Entrance Examination Board Test and the Scholastic Achievement Test, except where such tests are eing used for diagnostic purposes and not as a criterion for admission.

3. Assure the relevance of course work to the work xperience of the trainees. New courses often have to e developed or, at least, existing courses modified.

4. Give full academic credit for all courses in the urriculum and count the credit towards a 2-year ssociate of arts degree, or its equivalent, and make ll credits earned in the 2-year program fully transerable to an existing bachelor's degree program at hat institution or another cooperating institution.

5. Work with the Career Development Committees n selecting the courses, the places where they will e taught, and the instructors.

6. Work toward the development of appropriate upport service packages, which may include tutoring, academic and personal counseling, and field upervision.

7. Give courses relating to the trainee's experience rst—such courses as early childhood education, human growth and development, art for preschool children—to ease the transition for trainees who have een out of school for many years and have never had postsecondary experience.

nstitutional change

In the 2 years the projects have been in existence, most participating educational institutions have gone hrough a process of change, especially in their attitudes and in their admissions requirements, as they elate to economically disadvantaged adults. The hanges are more evident in relations to peripheral rograms, such as Supplementary Head Start Training, than they are in the institutional structure as a whole although this is changing.

In addition to the changes required for participating in the program, the following measures have een taken to accommodate Head Start trainees:

- Most institutions have eliminated the usual educational requirements for enrollment but have conditioned continuance in the program on the trainees' performance. Others require only that enrollees subsequently complete either the GED test or 12 to 15 hours of college-level credit with a C grade average, or both.

Children concentrate on the story as the college professor observes a Head Start employee who is also her student.

- In most institutions, trainees who have had no prior college courses can take courses normally offered only at the junior or senior level.

- Many institutions offer first year trainees credit for field work—a practice usually allowed only for senior or graduate students.

- Institutions permit faculty to travel to Head Start centers hundreds of miles away to conduct classes near the trainees' homes. Some institutions rotate the location of classes.

- Some institutions—for example, Skidmore College and Marshall University—have given credit to trainees retroactively for courses taken in an 8-week leadership training program offered by Head Start. Some offer compressed credit courses to accelerate training.

- All institutions allow students to participate in course selection, method of presentation, location, and even in selection of instructors.

- In many institutions, the method of instruction in courses for trainees consists largely of seminars, a method otherwise usually reserved for upperclassmen.

- Several colleges have encouraged the local Career Development Committee to recruit teachers. If they meet the accrediting association standards, the teachers become members of the college faculty.

- Some institutions have conducted special training courses for the instructors of trainees.

Successes and problems

What has the program meant to the Head Start trainees? Some trainees with little educational background have obviously had their perspectives broadened by the college level instruction. Some have advanced to new positions within the Head Start programs in which they were working when they were recruited for the training program. A few have advanced to become directors of Head Start centers or even of an entire local Head Start program; some few have even become instructors in institutions offering Supplementary Training programs; and some have found broadened opportunities elsewhere in the community.

For example, Mrs. Lois Culver of Montrose, Mo., the mother of five children, has received enough credits through the Head Start training program to obtain a temporary teaching certificate and a teacher's position in the Roscoe, Mo., public schools. During the spring term of 1968 she traveled 7,000 miles commuting from her home to the Central Missouri State College in Warren, Mo. Planning to stay in teaching after she receives a bachelor's degree, Mrs. Culver says she is "sold" on the HSST program "because it gives you a chance to help yourself."

A major problem remains, however, in providing opportunities for advancement for all trainees both within and outside Head Start. While most trainees have shown increased skill in their work with children and many have been given increased responsibilities within their programs, only a comparative few have advanced in salaries within their Hea Start programs—due, unfortunately, to inadequat funding. Even fewer have found jobs outside Hea Start that would be regarded as beginnings in a rea career ladder. The limited opportunities in the huma service fields for persons with less than a recognize degree or certificate is a real problem. The obstacle to such advancement can, in my opinion, onl be broken down through the further elimination o unnecessary barriers to educational opportunitie

Some specific steps needed within the HSST program are:

- Even greater flexibility within the participatin educational institutions in transferring credits between departments, and especially in accepting credits from extension work.

- More precourse and inservice training fo HSST faculty members in teaching educationall disadvantaged adults.

- Greater weight for Career Development Committees in decision making.

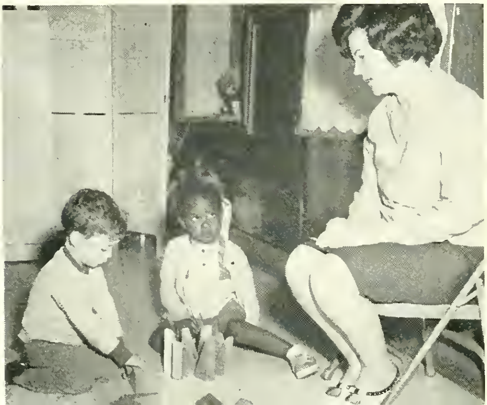
- The provision of more and better personal counseling to HSST trainees.

- Greater coordination between all groups participating in the program—especially Head Star directors, Career Development Committees, and th educational institutions involved.

Steps are being taken by the organizations involve to meet these needs. But the greatest problem wil require a concerted effort on the part of the huma service, business, and industrial communitie throughout the land: providing career opportunitie for all educationally and economically disadvantage adults who have entered in good faith into the various training programs available to them today.

Unless the development of opportunities for new careers becomes a national priority, thousands of th poor who have invested hope, energy, and time, an have made great personal sacrifices in securing additional education may construe these training opportunities as a cruel hoax perpetuated by th "establishment." As members of the economicall disadvantaged community their lives have alread been full of frustration. The lack of genuine opportunities for upward mobility after they have put s much effort in increasing their skill will represen the ultimate humiliation. *We must not allow this t happen.*

A Head Start employee applies what she has learned in her college training course to her work with preschool children.



THE GENERATION GAP

in the EYES of YOUTH

IZABETH HERZOG • CECELIA E. SUDIA

In my group of friends, the generation gap is the main topic conversation; we just don't refer to it by that name, but it boils down to the same thing.

To teenagers the problem is, "I just can't talk to my parents— y don't even try to understand." And to Mom and Dad it's illy just doesn't make sense. Some of the ideas he has are so lical!"

These remarks illustrate two major themes in the sponses received by the Children's Bureau from gh school students to the following questions:

We hear a lot these days about the generation gap. e'd like to know what your friends think about it, d whether they think about it at all. If so, what are e main things that adults do or say or fail to under- and that bother teenagers so much?

What about the other side of the coin? Do your iends think that some of the problems come from e teenagers? If so, what are the main things young ople do or don't do that make things worse?

In the spring of 1969 these questions were mailed a panel of 407 high school students randomly lected from students in college preparatory courses metropolitan areas situated in the four regions the United States—North, South, Midwest, West. eplies were received from 251 students in 53 schools 12 cities. The purpose was to find the main pattern- g of opinions among such young people rather than obtain an exact count.

The complete results are being published in detail the Office of Child Development as the first in a ries of *Youth Reports*.[1] Here we will present only outline of the general patterns that emerged— ong with some illustrative excerpts.

Experience with analogous studies gives ground r confidence that the opinion profile obtained in e Children's Bureau study validly reflects the views of urban high school students enrolled in college preparatory courses.

Teenagers are no more unanimous than their elders on most subjects. In their comments about the generation gap, for every complaint against parents and adults generally, there are conflicting or qualified responses. Some say that their complaint holds for some adults but not all, or for teenagers as well as adults. Often a single response covers a range of opinions, in an effort to say which kinds of teenagers are likely to hold the various views expressed, or to explain that the writer and his friends do not share a particular view. Nevertheless, the main lines of prevalent opinions are clear, and it is possible to differentiate between broad consensus, evenly divided opinions, and views voiced only by a few.

Is there a problem gap?

A wide range of opinions emerges about the existence and nature of a generation gap. About half the correspondents report that it is viewed as a real problem, and a few add that it is worse than in former years. The other half divides rather evenly between those who say it is not viewed as a problem at all and those who say it is seen as a problem by some young people but not by others.

In some instances the correspondent reports that it is not a problem for "me personally," or for "me and my friends," but that many young people find it a problem. Occasionally the latter are characterized as young people whose relations with their parents are not close, who do not appreciate what they receive, or who have been "brought up wrong."

We don't talk about the generation gap, as such, because we all recognize it and accept it. Thus, it isn't a topic, but an assumption behind conversation. For example, the remark, "I

had a pretty good talk with my Dad last night," is taken to mean that there has been a rare occurrence.

The substantial minority of the young people who dismiss the generation gap as a problem do so on various grounds. Over half report the opinion that a generation gap is normal and no worse now than in the past. Almost as many say it is seen as a problem mainly because it is "blown up by the media."

From the way my grandparents talk, I'm pretty sure that my parents weren't understood. Of course, I probably won't understand my kids either.

Some who downgrade the importance of the generation gap add that other problems are much more important—for instance, poor quality education, racism, poverty; that difficulties between people are a matter of individuals, not of generations. What we have, they say, is a "people gap" or a "love gap." And a few see the generation gap as an excuse made up by adults as "a blind" for avoiding the "real" problems.

The generation gap is, according to many kids—who have good relationships with their parents—an overemphasized, over-generalized, over-coined phrase, used to describe a rebelliousness occurring during the adolescent years accompanied by friction in the home.

A few, but very few, have a good word to say for the generation gap. Without it, they hold, there would be no progress. It forces teenagers to think for themselves, reach their own conclusions "so we will be a very determined people."

The nature and causes of the generation gap are discussed by many of the young people. By far the majority see it as a gap in understanding or communication. The most common complaint is that "they don't understand" or "we just can't communicate," sometimes because "they" (parents, or adults generally) don't want to, sometimes because they can't. Four out of five refer to failures of communication or understanding, or both.

Often the point is made with intense resentment against the failure of adults to try to understand, communicate, and explain. At the same time, a substantial minority view the communication failure more philosophically, as natural, inevitable, and probably chronic. And a few display sympathetic indulgence. "They can't help it," "they have their own problems."

Our parents are both reticent and communicative and they always seem to be one when it should be the other.

They don't *listen.* If we try to talk to them about a problem, they are either so involved in giving advice that they don't hear us at all or they aren't listening in the first place.

Most of the kids feel that it is just a lack of interest by both parties to talk to each other.

Parental sins

Lagging behind the failure to understand and communicate, but nevertheless bulking larger than other complaints, is a cluster of protests against the failure of parents to grant the teenager full status as a person entitled to respect and trust. Parents, the complaints go, do not respect the teenager's opinions, fail to recognize that his problems are important to him, and do not trust him.

On the one hand such shortcomings are associated with adults' failure to recognize that the teenager is partly grown up and worthy of certain responsibilities. On the other hand, adults are occasionally charged with not making allowances for the teenager's youth and expecting him to be more grown up than he is. Either way, the individual and his growth phase are felt to be belittled or ignored.

I just wish that sometimes they would give us a chance to show them what we have learned.

A less salient part of the sins-of-omission cluster is failure to give teenagers attention and love. Attention, however, is clearly not to be confused with the widely resented "nosiness". "They're too busy," "they don't take time," "they're too wrapped up in their own problems and fights," "it takes time to be a good parent," "kids rebel in order to get attention," "they don't give enough love."

Objections to what parents do stand out almost as much as objections to what they do not do.

Leading all sins of commission is the dual charge of rigidity and strictness: parents are always sure they are right; they refuse to reconsider what they have said, once they have said it; they are given to arbitrary rules and punishments.

The main thing adults do wrong is that they think things are either black or white, only positive or negative. No compromising. Having this attitude, just makes teens kind of "burn" inside, almost until they explode.

On the other hand, a few teenagers complain that many parents spoil children by being overindulgent and overpermissive. One or two associate such indulgence with an effort to "buy love," adding that this only breeds disrespect.

arents mean well when they try to give you all the things t they never had. They want your life to be better than irs was. But they don't realize that they might be forcing nething onto you, and when you "fail them" or "rebel," they nediately hit you with, "we've given you everything you've r wanted," or "where did we go wrong?"

A number of parental sins of omission are seen as ntributing to sins of commission: lack of undernding, refusal to listen, lack of trust and respect the teenager as an individual, lead parents to bene "nosy," suspicious, and inconsiderate.

A different kind of objection to parental behavior reported by about one correspondent in 10, but vays with intense feeling. This concerns parents io set a poor example for their children, who "say e thing and do another." Such parents are deibed with biting scorn as being "hypocritical," honey," "setting a bad example." They drink, they oke, they tell half truths, they practice "loose rality," and at the same time urge their children t to do these things.

A small, equally vehement number of respondents port complaints of parents who nag, "yell at their ls," and embarrass them in front of others.

For both boys and girls, lack of understanding d communication leads all complaints by a wide rgin. Girls put most emphasis on lack of respect d trust, often perceived as prying and interfering th social activities. Boys also put most emphasis rigidity and strictness but without specifying the ntext. Lack of attention and love ranks higher nong girls' complaints than among boys'.

nflict in values

Over one-third of the teenage reporters explicitly er to value clashes between the generations, and any more discuss value-related points in connection th other complaints. Often the references are genal: "We don't have the same values." "We have two posing philosophies." But more often the conflict specified: "They" are accused of insufficient inter- in the overriding problems of our day, including r, poverty, and racism. "They" are accused of terialism—over-emphasis on money, possessions, onomic security, status, individual achievement.

Corollary to both these accusations is the charge it "They" emphasize trivia at the expense of really portant things, insist on conformity in matters of ess and grooming, and judge people by externals.

Disapproval of parents' emphasis on nonessentials linked with indignant protests against adult objections to teenage preferences in hair styles, dress, and grooming. Over one-fourth of the correspondents report such objections. "Parents don't understand fashions are changing" or they think teenagers are "not responsible" if they are not dressed conservatively. Among both boys and girls the subject frequently concerns the hair styles of boys.

A very few of the young people criticize long-haired boys. One goes so far as to agree with his parents that "long hair is disgusting." On the whole, however, the teenagers defend their right to self-determination in dress and grooming, even though the defenders themselves may not exercise that right in ways deplored by their elders.

The teenagers tend to condemn the adults' "over-concern with external appearance" on two grounds: as reflecting a distorted sense of values; and as a violation of individual autonomy. Because of this dual significance, the reporters imply, teenage costume and grooming have taken on the attributes of symbol, of language, of badge, and of weapon—thus acquiring for the young an importance which may seem somewhat at odds with their objections to emphasizing external appearance.

For the first quarter of the school year I kept my hair short and very conservative—I made straight A's. Now that's what they wanted me to do and I did it (make the grades, not the hair). But, nevertheless, I did what they wanted me to, without any qualms, but I ask them to let me let my hair grow long and the answer is an emphatic "no!" I got the grades, either way (and that gives them satisfaction)—why not let me have my way?

Sometimes the correspondents try to explain the value differences they report. Some of these discussions are bitter, some dispassionate, a few indulgent. The chief excuse offered for their parents is that because they grew up during the depression they attach greater significance to economic security than their children.

Today's young people do not have to worry like their parents did about money and making a living. They can be concerned with other things . . .

Such comments are made by less than one in 15, and certainly not by those who report the views of the nonaffluent.

Nearly half the correspondents explain the value conflicts with adults in such statements as: "The world is changing too fast for them." Often the statement is made without explicit criticism. But more often it accompanies criticism of adults as resistant to change. The adults, it is said, not only fail to understand change but they definitely do not want it, while the younger generation definitely does. Thus, in a sense, change itself becomes a value—positive for the young and negative for adults.

> They have carved their own little niche in society and are fearful lest change will destroy it. We understand such fear. We can foresee the same fear ourselves when the next generation wants change.

Most bitter of all is the reported resentment against parents who want to make their children "into a carbon copy of themselves". "When I was your age" is a particularly detested phrase.

Some parents are o.k.

While the wording of our questions tended to invite criticism of adults, the responses do not picture parents and other adults in wholly negative terms. Some respondents—nearly one in 10—explicitly state that they share the values of their own parents. Very few of these correspondents describe themselves as "conservative." They more commonly describe their parents as progressive in their thinking, understanding of young people, and keeping up with the times.

Sometimes the correspondents contrast their own parents with the parents of friends or acquaintances—that is, they view their parents as nice but unusual.

> I am thought to be extremely lucky because I get along with my parents . . . I am the exception.

The world "mess"

Nearly a third of the correspondents confine their responses to a general consideration of whether there is or is not a generation gap. The remainder divide rather evenly into three groups: those who refer only to intrafamily relations and issues; those who refer only to social problems and issues; and those who talk about both.

Those who do mention society or social problems blame adults for allowing the world to get into "this mess." The positive social goals attributed to youth are pictured with varying degrees of specificity: to end war, to cure poverty, to "stop evils," to promote "spiritual and mental welfare," to reform political processes, to further peace, love, and brotherhood, to engage in community service.

> We are very much concerned about many grave problems, which threaten to destroy the advantages that civilization has given us. We are concerned about overpopulation, racism, poverty, pollution, and most of all, oppression and the stifling of the individual in what is supposed to be a democratic society. The reactions that we have seen to these concerns are very frustrating. School desegregation guidelines are relaxed . . . ; poverty programs are stifled because they might hurt the taxpayer; industry successfully blocks pollution control; and those who wish to democratize America are labeled Communist and suppressed, often violently.

The inevitable counter-point is presented by a very few dissenters who say teenagers are not really sc idealistic themselves, but are in fact materialistic and lack positive goals. However, not one correspondent reports that teenagers are content with society as it is.

The specific problems of society most frequently mentioned concern riots, protests and disorders, war, race, and poverty.

> . . . what really annoys many teenagers is the "accepting" view adults have. They accept war, poverty, hunger as unchangeable. The teenagers look at war for what it is—mar killing man senselessly. They see race riots, starvation anc campus trouble. No wonder they're disgusted.

Comments about forms of protest more frequently disapprove than approve violent and disruptive dissent. Nevertheless, those who are moved to discuss such matters are obviously in sympathy with the reasons for active efforts to bring about change. About one in 20 reports the view that "shock treatment" in the form of violence and disruption may be necessary in order to "awaken the sleeping generation. Almost twice as many, however, see a need to kee violent dissidents within bounds.

> Also, violent marches and occupation of college building seem to be carrying things too far. However, many of m friends feel that at times, a peaceful march can be importan to make grievances known. The inability of peaceful marche to remain peaceful is a major problem . . .

> A college is a place to learn—if the students don't like i they can go someplace else!

All comments concerning war in general and mos of those concerning the Vietnam war are strongl negative.

> We have to fill out c.o. forms to explain to you why w shouldn't kill, but you're the ones who should have to fill ou forms telling us why we should kill.

That these views are not necessarily unanimou is suggested by the fact that the majority of the co espondents make no mention of war at all.

Many correspondents make no mention of race roblems, but all who do are emphatic about the need o eliminate prejudice, discrimination, and inequaliies. Not one reports endorsement of a "go-slow" olicy. Little regional difference in views is pereptible. Among the very few who refer to interracial lating, all defend the practice as quite acceptable to outh though not to parents.

> I, as a teenager, think that because the older generations have olerated racism and other forms of human cruelty, their conepts are wrong and should be abandoned.

On the whole, the views of black teenagers resemble hose of white teenagers with regard to the existence nd nature of the generation gap, although the emhasis is clearly influenced by keen awareness of their pecial problems. The proportions of those affirming r denying a generation gap are comparable. Howver, those who belittle the problem do so with speial scorn, pointing out that the real gaps are between Uncle Toms" and all the others, regardless of age.

> The gap between aware blacks and unaware blacks is not ecessarily one of age. In most cases it involves the extent to hich one has been brainwashed by white America . . . Some eople as young as junior high school age have proven to be nore stubborn to the "de-brainwashing" process than some randparents.

Some reports from black students include poignant liscussions of problems that dwarf such consideraions as the generation gap.

> I am one of the twelve Negroes who attends a predomnantly white school of about 3,000 or more . . . I'm just like walking test at school. Now the Negro is on stage, performing efore an all white audience, trying to sway and correct their pinion of blacks.

The subject of poverty is among the least frequently nentioned in comments about specific social problems. To some extent, however, economic inequalities are implied in references to social problems generally and to race problems.

Teenagers on teenagers

In response to the specific inquiry about "the other side of the coin," over half of the reporters find some readiness to concede that there is fault on the part of both generations. About one-third did not respond to the question.

A number of teenage "sins" are specified, some of them mirror-images of those ascribed to the older generation. Teenagers, like adults, are accused of not listening and not communicating. About two out of five acknowledge that the obligation to give understanding, trust, and respect to their elders is often unfulfilled. About one in seven criticizes the young for not realizing that after all "they are still kids" and can learn from adults—although half as many report belief that teenagers really do know more about today's world than their parents.

> Some kids think it's all the parents' fault, but I think it's half and half.

> I think both sides need to do less talking and more listening.

In frequency and vehemence, criticisms of the older generation far outweigh criticisms of teenagers, and are less often qualified or restricted to an unrepresentative few. The prevailing view is definitely that the teenagers are not chiefly to blame for the generation gap; about one in 10 exonerates them altogether.

> But I just happen to think that the older generations are far more mistake prone, and will not face the reality when they are wrong.

Among the most indignant protests reported are objections to prejudice against teenagers as a group, levied in some form by about one in three, against parents, adults generally, and the "mass media." Nearly a fourth of all the correspondents concede that "some teenagers are really bad," but they usually add that the great majority are O.K. and should not suffer for the misdeeds of the misguided few. They maintain that adults expect the worst and act in such a way as to invite it.

> It seems they feel if one girl goes around with every boy in town and doesn't care what she does, that their daughter will do the same. They don't have enough faith in their own child-raising.

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The media, it is charged, aggravate such attitudes, by playing up only the bad and ignoring the good.

There are just that small minority of "weirdos" that there has always been, but, with the more publicity, they seem to be a larger group.

Mention of drugs comes in only incidentally, as an occasional specific under broader issues. Use of marijuana receives little support, and heavier drugs none at all. While drug users are sometimes described as "really bad," some sympathetic reference is made to the pressures that drive some young people to drugs.

These kids are looking for something better like maybe through drugs, boy you can't find it that way.

Hippies and Yippies are referred to by about one in 10 correspondents, chiefly in connection with the tendency of adults to blame all teenagers for the misguided deviance of only a few. Less than one in 20 reflect a neutral attitude toward or sympathy with hippie motives and aims although not necessarily with their behavior.

A minority group such as hippies, militants, drug addicts, draft dodgers ruin the reputation of the majority of good teenagers and terrify responsible parents.

Maybe that is why hippies dress as they do. They want to bring to their parents' attention that no matter how unkempt they are they can still love their fellow man.

Autonomy and identity

In one form or another, the drive for autonomy is conspicuous throughout the responses. Boys especially report a generalized protest against interference with "doing their own thing."

Adults' effort to control teenagers' appearance is regarded, on the one hand, as a defect in values—overemphasizing the trivial, judging the outward appearance rather than the inner man—and, on the other hand, as undue interference with individual autonomy. There is a tendency to contrast adults' emphasis on trivia and externals with teenagers' interest in broad positive goals and essential individual worth.

Parents are always looking after their teenagers like their parents looked after them. But times are changing and this brings more freedom and independence to the teenager. He wants to lead his own life and not the one that his parents try to force him into. Parents, WAKE UP!!! He has his own life to live.

Since the questions were focused on adults' behavior lapses, it is probably not surprising that direct or indirect references to teenage identity problems were rare in the responses. Nevertheless there are occasional reminders that young people are changing and groping, that one aim of young people is to "find themselves."

I still have 2 years of high school left, and I intend to keep struggling in that time to be able to live the life and learn the things I need to, as it is necessary if I wish to be the type of person I think I am.

A number of our correspondents are very explicit about their future opportunity to improve our society, and their determination to make the most of it. "We are the leaders of tomorrow," they declare, adding that they hope to improve on what their elders have done. They clearly believe in their own moral superiority.

We all know what kind of shape the world is in today, after the older generation had charge of it. Today's teenagers want to try and fix it, their own way, and if we don't succeed, it will be through our own mistakes, not through the mistakes of our parents. And we'll be the ones to have the power of changing the world soon.

Eagerness to help

The correspondents' wish for understanding and communication between the generations is underscored by the nature of their response to the invitation to communicate with their Government. The response rate (63 percent) in itself is remarkably high for mail interviews, which as a rule evoke less than a 33-percent response.

Not many comment directly on the request to contribute to *Youth Reports*, but among those who do only three comment negatively while 20 are strongly positive.

This questionnaire is just the typical kind of ineffectual thing the "older generation" would do—pardon my criticism—perhaps you'll get the new communication.

Thank you, great impersonal governmental edifice—for the first chance I've had to express myself.

I don't think it is a problem that can ever be solved, but Good Luck anyway. Maybe the government is good for something, and you can at least ease the pressure.

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youth as advisers to adults and vice versa

IERBERT S. STREAN

The present era is often described as an age of turmoil and drastic change. Young people everywhere are challenging the "establishment" of every type—papal authority, the nilitary, governmental bureaucracies, university adninistrators, teachers, and parents. College presilents have been resigning in large numbers, and eans, school superintendents, principals, and leaders f youth-serving organizations are being pressured "to prove" themselves to maintain their prestige and tatus.

Those of us who teach, counsel, and live with hildren and young people are feeling a strong obligation to examine our transactions with them. "Now hat students are voting members of the curriculum ommittee, what is our role with them?" teachers in olleges or high schools ask. Parents wonder about ow much sexual freedom they can allow their offspring without abdicating their responsibilities; and even therapeutic counselors sometimes question whether they are imposing too much "professionalism" on their young clients.

Like many others who live and work with young people, in recent years I have gradually become plagued by many self-doubts as I have reflected on my activities with the young, as a social caseworker, a social worker educator, and a father. At times I have wondered whether I have been acting too benignly and so as "too much of an equal;" at other times I have berated myself for being too dogmatic and insufficiently related to the young person's needs. I have read many articles in professional journals and held long discussions with colleagues, members of my family, and friends in efforts to clarify my uncertainties.

This article is an attempt to report the partial *modus operandi* and *vivendi* that has evolved after a rather long period of self-examination. While buttressed by a theoretical rationale, the formulations to be discussed have arisen largely through personal and interpersonal struggles.

Theoretical rationale

One of the most obvious modifications that has taken place in the last two decades in our society's child-rearing practices, educational efforts, and therapeutic interventions is that we have become more and more "child centered." Instead of feeding an infant on a predetermined schedule, we try to ascertain when he is expressing hunger pangs and then we give him something to eat. We await the maturation of his musculature before we train him to use the toilet. And instead of heaping a child with large doses of sexual information on his 14th birthday, we begin his sex education much earlier by answering his questions whenever he asserts his sexual curiosity.

In education, we speak of "reading readiness;" in psychotherapy and casework we "begin where the client is." As guidance counselors, we accept a youngster's resistance to accepting counsel, and as parents we frequently consult with our children in making family decisions.

Our theories of child development have paralleled these changes in our perspective. Psychosocial development is now regarded as more than the unfolding of instincts: the relatively new ego psychology emphasizes the "average expectable environment" and takes into account the ways the social network is transmitted to the child and transmitted by him.

The research of ego psychologists like Erikson [1] and Hartmann [2] has emphasized the need for the adult, whether teacher, parent, or therapist, to tune in to the child's spontaneous assertion of developmental needs and then to meet these needs. Consequently, the child who has "school phobia" for example, is now regarded as a youngster who is suffering not only from separation anxiety, but also from a dysfunctional social system in which the school, neighborhood, and home are not enacting roles entirely appropriate for meeting the maturational needs of the developing child.

"The corrective emotional experience" in psychotherapy,[3] the saliency of "object relationships" in dynamic psychology,[4] and the "opportunity structure" [5] in sociology are only a few of the theoretical constructs implying that helping agents and the social network must be constantly vigilant to the child's spontaneous expression of developmental needs. The appropriate parental, educational, or therapeutic stance, it is now alleged, should be dictated by the child's preverbal, verbal, or nonverbal expressions of need rather than by the adult's preconceived notions.

The classical experiment of Davis, in which infants managed on their own to eat nutritional foods without adult pressure, supports the theory that children are excellent judges of their own needs. The adult, however, must be there to listen and provide.[6] Lewin in his experiments with various types of adult leadership, demonstrated that adolescents are very knowledgeable about the amount and quality of limits, structure, and direction that they need.[7]

In social psychology much emphasis has been placed on mutual role expectations. Several writers have demonstrated that for a relationship to be harmonious and to be experienced as meaningful, role partners must be sensitive to each other's wishes. Studies of therapeutic and educational relationships within the framework of role theory particularly support this thesis.[8, 9]

The following examples are drawn from my social casework practice, teaching experience, and activities with my own children. They suggest that children and young people can offer helpful guidance to the adult when he attempts to counsel, teach, and live with them—in short, that they make eminently qualified consultants.

A casework example

Alfred, a 17-year-old high school dropout, who was a poor reader, was referred to me for social casework help. He was withdrawn from peers and adults, dressed poorly, ate irregularly, and seemed very depressed.

Inasmuch as Alfred had already defeated several guidance counselors and social workers, early in my first interview with him I said I guessed he did not "feel much like coming here." Alfred said I was right. He went on to say that he did not need help, that he knew what was best for himself, and that he hated anyone who told him what to do. He knew "the score." I asked Alfred what *was* best for him and he responded tersely, "Just leave me alone."

A 10-minute silence ensued and Alfred asked, "Can I go now?"

When I assured him that he *could* go, Alfred said, "At first I was sure you'd give me a long pep talk and tell me what to do. That was why I was ready to hate you, but now I'm thinking of coming back."

I told Alfred I would be glad to see him again if that was what he wanted.

In subsequent interviews, Alfred tried to test my sincerity and to ascertain whether I would professionalize the interview and explore his problems or let him set his own pace. He avoided a discussion of personal problems. Instead he discussed baseball, movies, checkers, and cops, and I joined in the discussion of these subjects when he asked my opinion. In the fifth interview Alfred suggested that maybe we could go to a baseball game together some day. I agreed that we might.

Subsequently, Alfred seemed to grow frightened of his positive feelings toward me. In his seventh session he said he would like to withdraw from treatment and not return for any more interviews. Referring to me as "baldy," he mildly ridiculed me for "smoking a stupid pipe," and "laughing peculiarly." When I asked him whether I should stop smoking

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nd laughing, he commented, "You really think I now what's best! Don't you?"

I responded with the question, "*Don't* you know hat's best?"

"Not always!" Alfred said.

Alfred went on to describe how he "cops out" when e "feels funny." He said that I knew about the easons for his withdrawal and suggested that I tell im. I wondered out loud whether when he began o feel close to someone he became scared and withrew, as perhaps he was doing "right now!"

In the next few sessions Alfred described several pisodes in his life that corroborated my theory. In is 15th session, he told me that he expected other eople to withdraw from him when he started to like hem so he decided "to beat them to the punch."

Soon after gaining this bit of insight, Alfred reurned to school and began a program in remedial eading and tutoring in several subjects. In his sesions with me, he went into a constructive discussion f his fears of being rejected.

My experience with Alfred demonstrates that when young person's autonomy, negativism, and resistnce to an adult are fully respected and not chalenged, he tends to feel less vulnerable. From Alfred nd other adolescents I have learned that young peole are so ambivalent about wanting advice that when hey are permitted to be in the "driver's seat" themelves—that is, to take the role of adviser—they nove much closer to the adult. Apparently, when he negative part of their mixed feelings is not quesioned, the more positive elements emerge.

Because many adults believe that their own knowldge, expertise, and experience places them in a posiion of "knowing more" than the young, they are ften reluctant to abdicate the role of advice giver. Iowever, a crucial factor for an adult in relating o the young person—particularly the teenager—eems to be recognition that if the teenager is allowed o stay in the "driver's seat" long enough, he will urn to an adult when he realizes that he needs lirection.

Student power

In these days of student unrest, young people and he adults in their lives are frequently engaged in a fracas over the issue of "power." Consequently, the nore important issues of sound curriculum, morale, nd educational objectives get sidetracked. It is easy for the adult to feel that his own power is being aken away, because to wrest it away is frequently the young person's initial goal. Arguments and counterarguments, demands and counterdemands about student and faculty prerogatives emerge, and the power struggle often does not abate until someone is psychologically or even physically hurt.

Use of the students as consultants on the concrete issues that they bring to their discussions with adult authorities can sometimes avert these struggles. The following example is from my experience as chairman of a casework sequence in a school of social work.

Early in the academic year I was approached by a delegation of students who demanded very belligerently that the casework curriculum be drastically revised. Their tone and manner seemed to invite a defensive argument. When I asked, "In what areas?" the students looked surprised. There was a silence of at least a full minute before a student answered, "It isn't sufficiently related to practice!"

"How could it be related more to practice?" I asked.

Another silence of about 30 seconds.

"The classes in school are too theoretical—they should be more specific!" bellowed another student.

Feeling a little irritated by now, but trying to maintain my "cool," I asked, "How can we be more specific?"

Another silence. Finally, one student said, "We have to learn more about psychodynamics."

When I asked the students what they would like, they decided to get together with their colleagues to prepare their demands in writing to present to me at another meeting because they had "just identified the problem in this meeting."

At the next meeting, a week later, my behavior at the previous meeting was characterized as being "on the defensive and not giving enough," and I was warned, "Don't tell us we're projecting!" Conceding that perhaps their charges were valid, I asked the students what we could give them.

"We want the 'dynamics' that we're supposed to get but aren't getting!"

The conversation then shifted to an examination of the casework curriculum and its relationship to the offerings of other departments. The students maintained that the faculty members were all "too sociologically oriented" and that the students needed more information on clinical syndromes. They said that they did not write anything up for this meeting "because this is your specialty."

I told the students what I thought they meant by clinical syndromes and they agreed that "this was the stuff." I also informed them that this type of material was supposed to be covered in another department. Then, at the students' suggestion, I arranged for consultations between the students, faculty members of several departments, and the dean. In these consultations, the students made concrete suggestions as to what could be added to their usual classes. Their suggested changes, which were adopted by the school, turned out to be rather easy to include in the curriculum. One student summarized the result as "really not a drastic change after all!"

In observing some of the negotiations between students and faculty in colleges and high schools, I have noted two themes that have characterized many of the encounters:

1. Frequently, the students' demands are voiced in such belligerent and intimidating terms that faculty members quickly yield. For a while, all seems fine, but a restlessness in both parties soon manifests itself. The faculty members, feeling they have been "taken," become punitive, and the students often complain later about having "too much responsibility!"

2. The students are told to abandon their plans immediately and leave the school. Both sides get more belligerent and bricks and police arrive. The power struggle goes on for some time.

In neither of these two types of situations are the students used as advisers. In the first instance, the students become anxious because their mentors appear too weak and they feel that they have too much responsibility. The second situation is almost self-explanatory—when the students find no one is listening to them, their anger grows more intense and a battle royal ensues.

My experience with the casework students suggests that the use of students as consultants in the full exploration of facts and issues can obviate battles and power struggles. Neither side appears weak so both retain their integrity.

A warning

One of the dangers of using young people as consultants is that the adult may utilize the procedure to abdicate his real adult responsibility, which the young person wants and needs him to fulfill. The following example from my own family addresses itself to this point.

Experiencing a great deal of ambivalence about sending our 7-year-old son, Richard, to Sunday school, my wife and I asked his opinion about whether he should attend. After he asked many questions about the curriculum, which we answered directly, his response to our question of whether he would like to attend mirrored our own ambivalence. Several conversations took place in which all of us listed the pros and cons, yet a decision was not being made.

Finally, our son said to us, "This is a thing you should decide for me. I'm not sure of the right answer."

Our use of Richard as a consultant in this instance helped us realize just when and where the adult's knowledge and experience had to be asserted. While children and adolescents are not always as direct as Richard was, they do give clues through restlessness, tension, and failure to come to a decision as to when the time is ripe for adult intervention.

Because children and young people are able to express their psychosocial needs spontaneously, it is incumbent on the adults in their lives to be vigilant to these needs and to meet them as quickly and as well as they can. While children do not directly verbalize their needs at every developmental phase, their needs are always communicated to adults in some way.

Children and young people are frequently ambivalent about submitting to the direction and counsel of adults, at least initially. Permitting the youngsters to be consultants to the adult can diminish their negativism and resistance so that the real issues can be faced—whether the issues be at home, school, or in psychotherapy.

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the goal of life enhancement for a fatally ill child

JOAN MORSE

Death from rheumatoid arthritis is a rare occurrence among children. Therefore medical facilities for the treatment of young eople suffering from this disease are rarely faced ith the need to deal with the meaning of death to heir patients, their patients' families, and the memers of their staff. Such facilities put their accent on ehabilitation for school or employment or, at the east, on as much self-care as possible. When they *are* onfronted with a fatally ill child, their staff memers may feel thwarted from the start, unless they ake a clear look at the ultimate purpose of medical are: to enhance the quality of life insofar as possible s long as life remains.

This kind of goal reevaluation, with consequent ffects on patient care, took place among staff memers of the Center for Juvenile Rheumatoid Arthritis t the Robert B. Brigham Hospital in Boston, Mass., uring the 3 years they cared for Linda M, the only hild who has died at the center as the direct result f arthritis since the center was opened in 1963.

During the years Linda was under the center's are, she spent 360 days as an inpatient, divided over our hospital admissions. The rest of the time she was nder the center's close supervision as an outpatient. rom the time of her first admission it was apparent hat she would not live to become an adult. Rehabilitation as a goal was out of the question, but it could e, and was, replaced by two goals for Linda and her arents: (1) enhancement of their lives for the remaining time they had together, and (2) mobilization f their strength to cope with the inevitability of death. The well-being of the other patients required a third goal: helping them deal with their feelings about Linda's long struggle and her eventual death.

Trained to work as a team,[1] members of every discipline represented on the center's staff—physicians of various specialties, social workers, nurses, physical and occupational therapists, and auxiliary workers—strove to achieve these goals. They designed a program based on principles that have been outlined in professional literature by persons whose work more frequently confronts them with impending death in children.[2, 3] For Linda and her parents these principles required:

- The provision of one strong, guiding physician to deal directly with the child and her parents, regardless of how many other physicians became involved in treating her.

- The provision of skilled nursing care by staff members who were sensitive to the meaning of the child's emotional reactions.

- The provision of social service to the child's parents to strengthen their resources in whatever way needed to deal with the impending crisis.

- The development of understanding on the part of the entire staff of the child's psychological defenses and the effects of her illness on her parents.

For the other children in the center, who not only knew and loved Linda but also were suffering from the same disease that she had, the principles required:

- The development of staff understanding of the anxieties aroused by what was happening to Linda.

- The provision of opportunities for each child to deal with those anxieties in his own way.

- The development of awareness by all staff members of their own feelings in relation to Linda's death and how these feelings might affect the other children.

First admission

Linda was 11 years old when she was first admitted to the Juvenile Rheumatoid Arthritis (JRA) Center on referral from a pediatric hospital. She has been chronically ill with arthritis since the age of 22 months. Psychological testing performed at the referring hospital had labeled her as mentally retarded, thus making her ineligible for admission to a hospital school that had been recommended for her.

Linda lived with her parents, three younger brothers and a baby sister in a small city near Boston. Her father, a salesman in a hardware store, was a former serviceman, and therefore her hospital expenses were met for a while by the Veterans' Administration. Later they were paid through Medicaid.

Linda's first stay at the Juvenile Rheumatoid Arthritis Center lasted 259 days. When she entered she had fever, pain, and so much limitation of motion in all joints that she was unable to walk. Examinations revealed marked destruction of the joints in her hips and hands and flexion deformities of both knees. A rectal biopsy confirmed a diagnosis of amyloidosis, a condition in which glycoprotein deposits gradually infiltrate vital organs, eventually causing death.

Immediately following the diagnostic workup, the director of the center personally informed both parents of their child's poor prognosis. At the same time he told them that everything possible would be done to help her develop her capacities for enriching the remainder of her life. Although many consultants assisted with the case as well as the hospital's resident physicians, who changed from time to time, one physician, the center's director, was in charge of Linda's overall care for the remainder of her life. Since Linda's condition fluctuated, the fact that her parents always knew who was in charge of her case gave them a feeling that there was somebody they could rely on at all times. It also helped them come to grips with the true nature of Linda's illness.

Gradually Linda's parents realized what the physician meant by a program to enrich Linda's life.

Periodic medical reevaluation of the effects of her medication kept her fever down and made her more comfortable.

Intensive physical therapy, carried out by a physical therapist under the supervision of an orthopedist, enabled her to walk again with the use of braces and platform crutches.

Occupational therapy taught her how to make many different kinds of things, often with other hospitalized children. Her productions included a planter, which she later used for growing flowers by her bedside, and puppets and scenery for a show in which she participated. The occupational therapist made cock-up splints to support Linda's wrists while she worked. She also taught Linda how to bathe and dress herself with the use of various devices. Soon Linda required help only in getting in and out of the bathtub.

Tutoring, first by a high school student working as a volunteer tutor during the summer months and later a professional tutor from the public school system, helped Linda with her studies. In a short time her academic work was almost up to the grade level for her age—an indication that, far from being mentally retarded, she was really very bright. Undoubtedly her previous low I.Q. score had only reflected the limitation of her experiences and the constant interruption of her schooling.

Gentle nursing care, provided by nurses who uncritically accepted Linda's tendency to gruffness and sarcasm, evoked her complete cooperation through many unpleasant, and sometimes painful, procedures. Skilled at "listening with the third ear," the nurses recognized that her negative remarks were part of a spontaneous mechanism for self-protection, developed over many years of illness. For example when Linda accused the head nurse of hanging one of her finger paintings upside down, calling the nurse a "dope" who didn't know "which end is up," the nurse took this as Linda's way of asking for reassurance about her ability to tell "which end is up." The nurses soon learned that Linda, who was basically a polite child, reserved her most sarcastic remarks for the staff members she liked and trusted most.

The nurses encouraged Linda's activities, and helped her participate in those of the other children hey even helped her change her hair style and apply mple cosmetics at a time when her adolescent roomiates were experimenting with lipstick and nail olish. They responded enthusiastically to her exciteient over the holiday and birthday festivities lanned for the patients by the center's occupational ierapy, nursing, and dietary services. Linda's parits and little brothers were always invited to these estivities.

Friendships with other children, the first Linda had ver really had with others of her age, developed long with her personality as she achieved greater hysical independence in the hospital. Her manner ith the other children was uniquely honest and diect, and she displayed a real sense of humor. All the ther young patients liked her. Moon-faced from her iedication and deformed from her crippling disease, he presented a grotesque appearance, yet she was ever teased by another child. The respect and genine affection accorded her by the other children was, i fact, unusual, for often handicapped children bolter their own fragile egos by picking on a child who eems even more "different" from normal children han they. The other young patients often laughed vith Linda, but they never laughed at her.

Helping the family

The responsibility for helping Linda's parents ieet their problems and plan for her extended care ay with the social worker assigned to the JRA Center. Assessing the parents' psychological health as asically good, the social worker tried to help them naintain normal family relationships insofar as posible throughout Linda's long stay in the hospital and prepare for carrying out the medical recommendations at home should Linda improve enough to eave the hospital. In spite of the distance between the family's home and the hospital, she encouraged the parents to visit Linda frequently so that they could maintain their feeling of closeness to her. Linda's mother took her first driving lessons at the age of 36 so that she could visit Linda at times when her husband was working or staying at home to care for the other children.

Not unnaturally, even this strong family showed signs of the constant strain of their child's illness. The mother especially felt depressed at times when Linda failed to respond to the medical treatment. As she discussed these feelings with the social worker, she recognized that her greatest fear was that she would be unable to cope with the tremendous demands of her family responsibilities. Having grown up under the shadow of her own mother's recurrent depressions, she seemed haunted by the fear that she might not be able to "keep going." The social worker assured her that, if need be, her doctor could prescribe one of the psychotrophic drugs that today makes it unnecessary for most people who are subject to recurrent mood swings to "drop out" from normal life. As it turned out, the only medication of this type that Linda's mother required during her daughter's long illness was an anti-anxiety agent for premenstrual tension.

Throughout her contacts with this family the social worker supported the authority of the father as the head of the family. While Linda's mother had grave doubts about her adequacy to care for Linda along with her other children, she left all crucial family decisions up to her husband. Linda's father made it clear from the beginning that he would not consider placing Linda in an institution for permanent care, although he realized that the burden of caring for her at home was an exhausting one for himself as well as his wife.

As the social worker came to know the father, she saw that he indeed had the inner resources to keep his family intact through the inevitable problems ahead. With ideas on fatherhood and child-rearing gained from a childhood in a stable, loving, and disciplined family, he regarded the challenge of raising a family under the constant strain of Linda's illness as a test of his own masculine strength.[4] Proud of his wife, he was confident that together they would "manage somehow."

When Linda's disease seemed under fair, if temporary, control and she had achieved a greater degree of independence than ever before, the medical team decided that both she and her parents could benefit by being together at home. Before discharging Linda, however, the team involved her parents in the cen-

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ter's customary predischarge "family training program." Through this program they had detailed discussions with the resident physician and the head nurse and repeated sessions with the physical and occupational therapists regarding Linda's physical status, her customary daily routine, and how much she could be expected to do for herself using the devices and skills acquired at the hospital. After these sessions in the hospital, Linda's mother began to feel much more confident of her ability to care for Linda at home.

Intervals at home

At home Linda tried out new experiences. She attended a drive-in movie for the first time in her life. She visited a mobile school unit where lessons in art and remedial reading were provided by the local school system to supplement home tutoring for severely handicapped children. She attended church.

For the first time in years Linda's parents felt that their home was offering their handicapped daughter a chance to grow and develop. Through the instruction they had received from the hospital staff, they helped her maintain her new degree of independence. Confident of the continuing interest of the hospital staff, they were able to give up their fear of having to place their child in a medical home.

While living at home, Linda received periodic medical checkups at the JRA outpatient clinic by the senior physician in charge of her case. She always used her clinic visits as opportunities to visit with her favorite nurses and her friends who were still in the hospital or who were attending clinic that day. Knowing that Linda would one day return for inpatient care, the social worker helped her maintain her ties with the inpatient department by helping her find the nurses to whom she was especially attached.

Two subsequent periods of hospitalization sustained Linda during acute medical crises so that she could again return home. At the time of the first readmission, her father recalled how "torn apart" he had felt when he had had to return her to other hospitals, but he said he felt "all right" about returning her to the Robert B. Brigham Hospital because so many people there "cared."

Linda's third admission was particularly difficult for her parents. The mother had become pregnant and developed phlebitis and had been warned by her doctor to limit her activity. The hospital social worker urged the parents to apply to the local family agency for homemaker service, but they preferred to manage alone with the help of the other children. Retaining their independence as much as possible seemed to bolster their strength to prepare for further crises.

The final admission

Several weeks after Linda was discharged from the hospital for the third time, her favorite nurse received a note from her reporting the arrival of a new baby sister. Then, only 10 days after the new baby had arrived, Linda, now 13, was readmitted to the hospital through the emergency service. She had suddenly developed acute trouble in breathing. The only bed available for her was in a room with four other children. One was a friend of hers, 10-year-old Kathy. During her second night in the hospital, Linda developed convulsions and suffered a brain hemorrhage; she was then moved to a private room.

Kathy had been awake during the emergency room procedures associated with this episode. The next morning she asked to talk with the social worker, who had known both children for a long time. She told the social worker in great detail what had happened the night before. Thinking Kathy might be afraid that the same thing could happen to her, the social worker told her that Linda's critical condition had no relation to the kind of arthritis for which Kathy was being treated. However, Kathy showed no interest in the worker's intellectual explanation. She simply said she wanted Linda to improve quickly so they could be roommates again.

A few minutes later, however, Kathy began to sob. She said she was worried about her pet dog who had been run over several days before. A telephone call to Kathy's home brought the news that her dog was "off the danger list," and Kathy quieted down. Unable to face her fear that she might meet the same fate as her friend, Kathy managed to displace her worries about Linda *and* herself onto her pet, whose accident was much easier for her to discuss and to cry about. Displacement of this type is commonly used by hospitalized children to deal with the suffering they witness.[5]

After the brain hemorrhage, Linda was given last rites by the hospital's Catholic chaplain. The senior physician in charge of her care telephoned her parents to tell them her condition was critical. Both parents came to the hospital at once to see Linda, but she was unresponsive.

When parents realize their child is about to die, ney sometimes relieve their feeling of utter helpssness by transforming it to anger against another erson.[6] After seeing Linda in a comatose state, her ather sought out the resident physician and angrily old him he would not permit an autopsy, although no ne on the staff had mentioned this. In anticipating er death he was, in a sense, already beginning to repare himself for her loss. Some observers have oted that when parents facing the loss of a child ave an opportunity to express their immediate feelgs, they can function better afterwards.[7] This eemed to be so with Linda's father for after his outurst against the resident physician he was able to ke hold. Recognizing the importance of getting his ife home to the new baby and the other children, e took her away from Linda's bedside saying, "These hings can go on a long time."

Linda was unconscious the last 3 days of her life, ut her mother came to the hospital every day. Durg her visits she would sit with Linda for a while nd talk briefly with the resident physician. She pent a great deal of the time with the social worker iscussing what was happening and her feelings bout Linda. She told of how she and her hubsand ad at first thought Linda would again pull through crisis and of how much Linda had enjoyed the ew baby and had helped to choose the baby's name. etween her visits to the hospital, she made frequent elephone calls to the social worker for information bout Linda.

Linda died peacefully at 3 o'clock one Sunday orning. Her devoutly religious parents seemed to nd solace in learning that several nurses, who had olunteered to stay with her at night, had joined toether at her bedside to recite the Rosary.

Several weeks later, Linda's parents gave her foldg wheelchair to the hospital. Later, they came to e hospital together to show the new baby to the aff. At Christmas, in spite of their many obligaions, they sent a check to the hospital in Linda's emory, because she had always had "so much hristmas spirit and enthusiasm."

taff and patients

While Linda lay dying, regularly scheduled team onferences gave staff members an opportunity to iscuss their ideas of what her impending death ould mean to the other children on the floor. Inevibly the attention had to be turned to the feelings f the staff members themselves, for the discussions oon revealed the truth of observations that hospital staff members are no more immune than their patients to feelings, fears, and anxieties concerning death.[8] Already a young nurse had told a child that Linda had been moved to a private room because she had a cold. In doing so the nurse may have been protecting her own feelings rather than those of the child.[8]

Members of the team that had been directly participating in Linda's care particularly had to face their own feelings. In a team meeting someone suggested telling the other patients that Linda had been transferred to another hospital. This suggestion brought up the question of how such evasion would affect the children's ability to trust adults. Moreover, it soon became obvious that the hospital "grapevine" was providing the other patients and their parents with frequent, if inaccurate, bulletins on Linda's condition. The team decided to be honest with the children and to help them master their feelings realistically.

After the team meeting, the social worker got in touch with the parents of the four other young arthritic patients in the hospital, for by this time the parents of all the arthritic children registered with the center had developed a special closeness with one another. Kathy's mother asked to be called if Linda died so that she could be with Kathy directly afterward.

However, on the morning after Linda's death a floor nurse who was helping Kathy with her morning routines told her that Linda had "gone to heaven." Kathy, a sensitive child and devoted to Linda, immediately said, "You mean she died, don't you?" Her directness suggests that children are sometimes ready to deal with death more realistically than adults.

When a social worker visited Kathy later that morning, Kathy asked her for some paper to use for a letter to Linda's parents. She wrote, "I hope the new baby will take Linda's place."

This time it was the social worker who became protective of people's feelings. She encouraged Kathy to try a less blunt version, and Kathy decided on, "I hope the new baby will grow up to be as nice as Linda." Her original thought was less gracious than the first but probably more accurate in terms of parental hopes. Replacement of a deceased child by a new baby, often expressed as a desire by bereaved parents,[7] had in a sense already taken place in this family.

Not long after Linda's death, the staff of the center had another experience that revealed to them some of the ways children find to cope with the impending death of a friend. A 7-year-old child named Helen was admitted with symptoms of arthritis. She became rapidly worse systemically and progressively withdrawn psychologically. The only person to whom she would respond was 9-year-old Judy, her lively and outgoing roommate.

After further studies indicated that Helen was suffering from leukemia, she was transferred to another hospital. By this time, she was almost completely mute. Because the transfer was accomplished the same morning the diagnosis was confirmed, the arrangement was not explained in advance to Judy, who had spent the morning in physical therapy.

When Judy returned to her room, she was furious to find that Helen had gone. Her first words were, "How could she leave without saying goodby to me?" She completely suppressed her knowledge that Helen was far too sick even to talk to her.

When her anger subsided, Judy began to discuss Helen as if she had been the most charming and responsive friend she ever had. She filled in for herself all the desirable personality traits that were inhibited by Helen's illness. The staff members accepted Judy's statements as necesary for her, remembering how the children who knew Linda could speak of her only as a loyal friend and never of her condition as a dying child.

The meaning

What did the hospital team members learn as they worked with Linda and her family? They learned that—

1. Comprehensive treatment can enrich the quality of life for a fatally ill child for whatever time remains.

2. The development of good relationships with the patient's parents during the remaining life of a fatally ill child can make it easier for the family to cope with the crisis of death, and to carry on effectively afterward. The experience with Linda's family is consistent with observations of Lang and Oppenheimer who in reporting on a study of 165 fatally ill children noted that human beings show "the capacity to mature and grow in the process of learning to cope with severe stress."[9]

3. Children can often cope with their feelings about death and dying more realistically than adults expect them to. If they cannot face their feelings, they can readily displace them onto some less threatening situation.

4. Regular opportunities for communication help team members deal with their feelings openly and constructively at times of crisis as well as formulate unified plans for patient care.

In Linda's case a child's unique spirit, courage, and humor, developed in response to the care she received, helped everyone—her parents, the staff members, and other patients—to triumph over the knowledge of inevitable death.

In a very real sense the experience confirmed the truth of Arnold Toynbee's words: "Love cannot save life from death, but it can fulfill life's purpose."

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SOME HIGHLIGHTS FROM THE NUTRITION CONFERENCE

MIMI SIMMS

Associate Editor

Guidelines for ending hunger and malnutrition due to poverty in the United States and for a broad national effort to improve the nutritional health of all citizens were presented to President Richard M. Nixon on December 24, 1969, from the White House Conference on Food, Nutrition, and Health that met in Washington, D.C., December 2–4. In transmitting the report, Conference Chairman Jean Mayer, the President's special consultant on nutrition, pointed out that the first priority of the 3,000 participants was a commitment to action to alleviate hunger.

In response to recommendations of the White House conference, the U.S. Department of Agriculture has taken action to broaden its food stamp program for low-income persons by reducing the cost of stamps. An eligible family of four can now buy $106 worth of food stamps a month (compared to an allotment as low as $58 in December 1969), with payments ranging from $2 if the monthly family income is less than $20, up to $82 if the income is $359. Additional steps are being taken by the Federal government to reach the following goals:

- Food stamp or food distribution programs in operation in every county in the United States by June 30, 1970, including the 307 counties that did not have a Federal food program at the time of the conference.
- Free or reduced price lunches for 6.6 million children from low-income families by Thanksgiving 1970.

The national conscience requires us to "put an end to hunger in America," said President Nixon in addressing the conference. Considering the effects of malnourishment, he said: "A child ill-fed is dulled in curiosity, lower in stamina, distracted from learning. A worker ill-fed is less productive, more absent. The mounting cost of medical care for diet-related illnesses; remedial education required to overcome diet-related slowness in school; institutionalization and loss of full productive potential—all of these place a heavy economic burden on a society as a whole."

Participating in the conference were nutritionists, physicians, teachers, students, public health workers of various types, food producers and processors, food service industry personnel, representatives from local, State and Federal Governments, and leaders of consumer and voluntary action organizations. In addition, 400 attended as representatives of the poor, including members of racial and ethnic groups—Negroes, Caucasians, Mexican-Americans, Puerto Ricans, American Indians, Alaskan natives, and residents of Pacific Trust Territories and Caribbean Islands.

The real work of the conference was the hammering out of final recommendations based on preliminary statements prepared by groups of experts who met in the fall of 1969. This procedure was carried out in the open sessions of 26 study panels and eight task forces. Their discussions were focused on six major topics: surveillance and evaluation of the state of nutrition of the American people; guidelines for the nutrition of vulnerable groups, with special reference to the poor; provision of food as it affects the consumer—guidelines for Federal action; nutrition teaching and nutrition education; food delivery and distribution as a system; and voluntary action to help the poor.

The participants looked at problems of food and nutrition in a broad social context. One study panel concluded, "Nutrition needs cannot be met in isolation from other basic needs for shelter, clothing, health care, education, love, and environmental support to modify conditions of social deprivation." Another panel pinpointed lack of income as the basic cause of hunger and malnutrition. Its members said, "Unless a family can be assured sufficient income to provide a level of adequacy for all basic items of living, nutrition education is predisposed to certain failure."

Against hunger

Estimates of the number of hungry and malnourished in the United States ranged from 10 to 15 million persons; middle-income as well as low-income participants at the conference stressed the need to feed the hungry, "not to survey them again." One panel was told that three-fourths of the estimated 25 million poor people in the United States were not reached at all by Federal food programs at the time of the White House Conference.

Agricultural economists assured other panels that the current production of food is more than sufficient to supply the nutrient needs of every member of the U.S. population. Reported one panel: "We have all the knowledge and resources needed to completely eradicate hunger and malnutrition now." The task force from religious organizations declared, "The curses that afflict our society stem not from hunger and malnutrition, but from our own irresponsible indifferences."

A five-point statement prepared by several task forces representing citizens' groups was endorsed in principle by voice vote at the final conference session. The statement set priorities for attacking hunger and malnutrition, which involved the following principles:

1. Recognition of a "national hunger emergency" and use of existing authority to free funds and implement programs to "feed all hungry Americans this winter."
2. A minimum guaranteed family income.
3. Immediate reform and expansion of present interim food programs—food stamps, commodity distribution, emergency food, and medical services—to assure "truly adequate benefits and participation by all who need them" until "adequate income becomes a reality."
4. Immediate broadening of the national lunch and breakfast programs for school and preschool children.
5. Transfer of administrative responsibilities for all hunger relief and nutrition programs to the Department of Health, Education, and Welfare, giving recipients responsibility for local administration of the program under standards determined by the Federal Government.

The specifics of the antihunger priorities were the subject of some disagreement among conference participants. For example, some participants argued that providing free school breakfasts and lunches only for children of low-income families stigmatizes the children receiving them; they advocated free food programs for all children to assure that nutritional needs are met. Other participants questioned the practicality of providing free school food programs for all children because of the cost to the government.

Controversy also arose over the amount—but not the principle—of the guaranteed adequate income. A professor of economics said that the assurance of $5,500 for a family of four, suggested in the task forces' statement, would cost $70 to $80 billion annually. Some participants suggested an even higher income level, citing $7,836 as a "moderate" income for an urban family of four in 1967.

Dr. Mayer pointed out that the conference vote was only an endorsement of principles and not a commitment to any specific figures.

Mothers and infants

Three panels recommended that breast feeding of babies be reemphasized in nutrition education programs for the "vast majority of women who are physically and emotionally capable of nursing their babies." Discussions in one session called for teaching physicians, nurses, and other health workers how to help a mother nurse her child successfully. In describing breast milk as the "perfect food" for meeting an infant's nutritional needs, one panel pointed out that its benefits include "protection against infection and allergies that cannot be duplicated."

The panel to establish guidelines for the nutrition of children and adolescents recommended highest priority be given to assuring adequate nutrition for the fetus, infant, child, and adolescent. A pediatrician described the needs of pregnant women, young infants, and children and called for well-planned nutrition and feeding programs to prevent intellectual impairment resulting from malnutrition.

Nutrition of the entire family must be considered as a unit, according to the recommendations of several panels. The panel on the nutrition of pregnant and nursing women and young infants branded as "unrealistic" programs that assume "some family members can eat less well than others while all are seated together at the family table." The panel opposed programs to make food available solely for pregnant women and infants, although it acknowledged their special needs.

The same panel expressed concern about the poor nutritional status of many adolescent girls, pointing out that nutritional status from infancy onward affects the outcome of a woman's pregnancy, and so the health of generations to come. Adolescent girls in particular are vulnerable to the casualties of pregnancy, panel members said; when such girls are poorly nourished, they and their babies have a disproportionately high rate of maternal and infant mortality and birth defects.

Two panels differed in their views of the addition of salt to commercially prepared baby foods. The panel on nursing women and infants found "no scientific basis" for removing salt from baby foods, but recommended continued collection and examination of data in this regard. One scientist maintained that salt meets a major physiological need of infants who consume a die high in potassium, and warned of acidosis in breast-fed infants who receive supplementary vegetables and fruit without added salt.

On the other hand the panel on children, after hearing a report of experiments in which the addition of salt to the diet of rats produced hypertension concluded that reduction in amounts of salt in commercially prepared baby and junior foods is "desirable."

It was pointed out that the controversial issue of salt in baby food is presently under study by a committee of the National Academy of Sciences.

Surveillance and research

To find out what the Nation's continuing nutritional problems are, one panel proposed that the Department of Health, Education, and Welfare make a long-term survey of national nutritional status. Priorities were suggested for monitoring the diets of preschool children, expectant mothers, primary school children, and low-income groups.

"Certain segments of our population—particularly some infants, preschool and school-age children from low-income families—do not receive enough food," one panel reported. Participants referred to studies finding low levels of calorie and protein consumption and unacceptable levels of iron, vitamin A, vitamin C, and iodine intake among such children. The panel on children and adolescents reported that these deficiencies, while all individually serious, are not nationwide problems—except for iron deficiency.

A number of panels agreed that adequate income does not automatically insure proper nutrition. Too many calories, too little physical activity, obesity and unwise food choices are problems that the poor share with the affluent. In spite of the excellent information on nutrition and health that is available today, one panel said, many children are given potato chips and a bottle of carbonated drink for breakfast.

The establishment of a Federal office or commission or both to coordinate expanded nutrition activities was sugtested by several panels. Conference participants acknowledged the need for additional research relating nutrition to human growth and development, mental retardation, diseases, new and customary foods, food safety, and many other areas, and the need for more professional nutritionists, new careers for nutrition aides, and training of teachers, health personnel, preschool center staff members, and food service workers who influence food habits of others.

Some recommendations

Among the hundreds of other recommendations contained in the report are the following, in brief:

- Steps to prevent and eliminate iron deficiency anemia in infants, preschool children, and women through the use of iron-fortified foods or medicinal iron, including a study of effective ways of fortifying some basic foods with iron.
- Expansion of day care centers, with adequate nutritional services, for preschool and school-age children, to serve [illegible].5 million children by 1975.
- Fluoridation of drinking water, the provision of fluoride supplement, or the topical application of fluoride to the teeth of children to prevent or reduce dental caries.
- Education about the damage that candies, confections, and beverages containing sucrose can do to children's teeth, and development for vending machines of new types of snacks that do not contain sucrose.
- Prevention of obesity through the encouragement of vigorous physical activity for children from preschool through senior high school under trained physical education instructors, and the use of school facilities for supervised physical activities and recreation during nonschool hours.
- Programs to meet the nutritional and activity needs of handicapped and institutionalized children.
- The provision of low-calorie foods for overweight children in lunches served at school and preschool centers.
- Federal regulations to sustain family income of working women during pregnancy by establishing standard practices for unemployment compensation and assuring job security.
- The provision of family planning information and services to all who request them, including adolescent girls.
- A major nationwide program to attack the problem of drug usage among teenagers, "since drug users often have flagrant nutritional deficiencies."
- Fortification of staple foods (such as flour, bread, noodles, rice, processed meat, corn meal, and other corn products) with proteins, amino acids, vitamins, and minerals, and a program to educate consumers on the benefits of fortified foods.
- Reemphasis of the need for iodized table salt to prevent goiter, a health problem beginning to reappear in some parts of the United States.
- Development of supplemental edible protein sources from fish concentrate, glandless cottonseed, and micro-organisms.
- Regulations that assure food safety but permit the production of nutritious and economical foods, both customary and new.
- Improved labeling of foods in terms that consumers can understand, to disclose facts related to nutrition, health, and safety.
- A comprehensive National Nutrition Program, providing new approaches to the achievement of good nutrition and adequate knowledge about how to use available foods effectively, aimed at all age groups, but designed especially for the "ordinary citizen."
- Establishment of community nutrition centers to provide education and consultation to persons with nutritional problems and training for nutrition aides.
- Increased Federal financial support for training nutritionists and dietitians.
- During the interim until food stamp programs are discontinued, flexibility in regulations to allow the use of food stamps to buy cleaning materials as well as food; elimination of sales taxes on food purchased with stamps; and self-certification by recipients and delivery of stamps through post offices to preserve the dignity of recipients.
- Adoption of a 1970 Children's Emergency Food Service as a crash program to feed all school children who are high nutrition risks. This program, as proposed, includes federally financed school breakfasts that are coordinated nutritionally with school lunches.

President Nixon has said he will call a small followup meeting about 1 year after the conference to reexamine the findings and measure what progress has been made toward implementation.

Providing a nutritious school lunch—such as the one these girls are enjoying—to all hungry children in the United States free or at reduced cost is one of the priorities set by the 1969 White House Conference on Food, Nutrition, and Health.

an essay review . . .

MOBILIZING FOR OPPORTUNITIES FOR YOUTH

MARY BLAKE

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● Those of us who lived and worked in the last two decades to create public awareness of problems of the poor, neglected, and delinquent and to develop new services for them will derive satisfaction and benefits from reading the recently published four-volume history of Mobilization for Youth,* the innovative demonstration programs for controlling delinquency in New York's lower East Side. It is written with unusual candor, honesty, and obvious emotional dedication by 19 authors, who were all closely involved in the program's planning and operation. They experienced failures as well as successes; weathered internal struggles between widely differing viewpoints and professional orientation; and withstood attacks from outsiders over the first 5 years of this unique organization's life.

Child development specialists tell us that the first 5 years of a child's life are crucial to his development as a productive, social being. If the same is true for social institutions, Mobilization for Youth (MFY) may well enjoy a long and productive life.

Each of the four volumes can stand alone as a useful document. Together however, they project a picture of the evolution of program activities and services based on the application of the opportunity theory, which has greatly influenced delinquency control programs as well as recent attacks on poverty. Thus, limiting one's reading to part of the history is not recommended. The volumes are relatively brief, succinct, and helpful in identifying why there is such an emphasis today in giving people a voice in planning and operating the services they use.

Probably more has been spoken and written about MFY than any other single voluntary social agency in the United States today. It would be impossible here to describe or even enumerate all of its services. The books do that. Instead I will present only some of the highlights, issues, and conclusions they contain

Individuals and groups

The volumes are not numbered but since MFY grew out of the desires of Henry Street Settlement and other social agencies in New York's lower East Side to reach and serve alienated, acting out, opting out, and delinquent young people and their families, I will begin with the one entitled, "Individual and Group Services."

MFY attempted to develop a new casework method—an approach to helping people that emphasized altering behavior and personality through the reconstruction of social circumstances buttressed by supportive casework relationships. It placed emphasis on meeting the needs of slum dwellers by providing easily accessible, immediate, and concrete help through neighborhood service centers. Since MFY sought to serve the economically lowest 20 percent of the population, the decision to concentrate on improving the clients' material well-being was a logical one.

Experiences of staff members in th centers soon propelled them into becoming active advocates for the poor In this role the MFY worker was t intervene with an agency, usually government agency, on behalf of th client. What the worker did, in fact was to fill the power deficit by actin as the client's defender. Another majo purpose of the caseworker's role wa to help effect institutional change.

Another MFY departure from traditional methods of providing individua services has been its use of "indigenou personnel"—people from the communit being served. These new workers ar not only providers of services, they ar interpreters of the slum to the profe sional staff. They also interpret to slum dwellers the presence of communit workers otherwise seldom encountere on their streets and tenement stairways

The section on individual service closes with the following observation:

"There is, however, a trend towar acceptance of the idea that in work wit the poor, training is crucial, but tha training need not be university training. The indigenous personnel themselves classify the MFY clients int approximately three groups: One grou needs only knowledge to help themselves; a second group needs knowledg and the support of a friendly agency organization, or social worker; thos in the third group cannot help themselves, either because of the sheer number of their accumulated concrete problems or because of disabling emotiona problems."

The early work with youth gangs—the inspiration for the initial attempt of lower East Side agencies to obtai funds to work with delinquents—developed a purpose and a focus from opportunity theory enunciated by Lloy E. Ohlin and Richard A. Cloward. A pointed out in "Individual and Grou Services," opportunity theory was base on the assumption that "in order t reduce the incidence of delinquent behavior or to rehabilitate persons wh are already enmeshed in delinquent patterns, we must provide the social an psychological resources that make conformity possible."

MFY has put its major effort o providing opportunities for jobs, edu cation, and a variety of social an medical services. This approach to de inquency prevention represents an almost complete shift from the original approach of most of the agencies in the area, which had envisioned stepped-up group and recreational services. What happened was that such familiar programs became the means for discovering and recruiting young people for participation in other programs and services provided through MFY.

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*INDIVIDUAL AND GROUP SERVICES—In the Mobilization for Youth Experience—192 pp. EMPLOYMENT AND EDUCATIONAL SERVICES—224 pp. COMMUNITY DEVELOPMENT—190 pp. JUSTICE AND THE LAW—220 pp. Harold H. Weissman, editor. The New Social Work Series. Association Press, 291 Broadway, New York, N.Y. 10007. $4.95 each.

In the concluding chapter in this volume, the editor, Harold Weissman, says that there has never been any clear answer as to the wisdom of this decision. He indicates, in fact, that MFY did not use the power of peer groups sufficiently to support a number of program ends. He goes on to suggest that the role of group-service agencies might well be to relate their informal group programs to school curricula and work crew skills in order to bring relevancy to all of the young people involved.

Employment and education

Employment and education services were the major thrusts of MFY. Their objectives were to increase the employability of young people from low-income families by helping them develop useful types of skills; to increase the number of employment opportunities for the same group of young people; and to increase the visibility of job opportunities open to them.

In the volume, "Employment and Educational Services," MFY's attempts to achieve these objectives are credited with influencing the development of the program of the Neighborhood Youth Corps under the Office of Economic Opportunity. These services highlighted a major issue that has permeated much of the MFY program: Is the agency's primary role to demonstrate or to provide services? When it comes to jobs or training for jobs, potential clients have asked this question. According to Mr. Weissman, it has never been answered with complete satisfaction to everyone.

This volume concludes that the major problem that youth-employment programs must address themselves to is the trainees' sense of competence. It is today's world of work that is the core of youth's problems and needs. However, the social structure must achieve a better balance between job training and general education in relation to the total economy.

MFY's five-pronged educational effort consisted of teacher training, curriculum improvement, activities to improve school-parent-community relations, attention to reading and other learning problems of students, and guidance and attendance services. None of these efforts has been welcomed wholeheartedly by the schools. In fact an aura of distrust developed early and has never been dispelled. This has led MFY to conclude that demonstrations should be attempted only if the responsible parties on all sides have agreed to become committed to aspects of the demonstration that are proved to be effective. Since it has not met with this sort of commitment on the part of school authorities, MFY admits to having achieved very little improvement in the New York City school system.

Another cogent reason identified for part of the failure to achieve change in the school system was that despite the seemingly large MFY expenditures for educational activities, the total amount represented only about 5 percent of the school budget in the area.

Community development

The community development part of MFY activities has consisted of a mixture of social services, social protest, and social organization. From the beginning MFY's goals have been to organize the community to increase the residents' awareness of its problems; to raise public issues concerning the community's needs; and to attempt to overcome the sense of powerlessness, apathy, and self-depreciation that are generally characteristic of slum-dwellers.

At first MFY attempted to achieve these goals through organizing individuals, especially persons unaffiliated with any community organization. It discovered, however, that the unserved and unorganized were more interested in securing immediate help and access to MFY's fiscal resources than they were in securing a voice and power in community affairs.

This desire for concrete help led the agency to phase 2, in which it attempted to organize people on the basis of issues that, when resolved, had a chance of producing tangible results. It moved from creating small organizations to mass protests.

Skepticism about what could really be achieved through mass protests led to the third, or coalition, phase of the program. This phase produced the ultimate conviction that the intermixture of the three phases was the most useful procedure for bringing about improvement in the slums.

Other chapters in this volume describe in great detail particular aspects of MFY's services and activities. There is also a very frank appraisal of the attack on MFY, which the organization survived. The following quotation is pertinent:

"To make the public at large aware of social issues and potential solutions is a major function of social agencies."

Justice and the law

Not until some time after MFY began operating other programs did the staff become conscious of the need to set up a legal services unit. What finally evolved was a unit with a three-pronged function: (1) to provide direct and referral services to people in the area; (2) to give legal orientation to staff members, clients, and community leaders; and (3) to use the law as an instrument for securing social change.

The success was striking in the first case, and adequately successful in the second, but in the third, the historian admits that it was not very successful.

"Justice and the Law" contains a chapter on administration by MFY's current director, Bertram M. Beck, that is "must reading" for anyone interested in what can be learned from MFY's successes and failures.

In analyzing MFY's attempts to produce social change in the lower East Side, Mr. Beck points out that the pace of this sort of endeavor has accelerated greatly in the last decade, with the help of Federal funds available for delinquency prevention and antipoverty programs.

But Mr. Beck says that the agency has concluded that only the redistribution of wealth can make a significant dent in social pathology. This belief has led the board and staffs to redesign MFY's program and to give it a new name that describes a new purpose: Mobilization for Economic Opportunities.

Thus MFY (now MEO) remains an avowed renegade from traditional programs based on psychological theory. Instead of helping its clients to adjust to the *status quo*, it will continue to work for institutional change.

BOOK NOTES

FAMILY PLANNING PROGRAMS: an international survey. Edited by Bernard Berelson. Basic Books, Inc., New York, N.Y. 1969. 310 pp. $7.95.

"No problem is more urgently important to the well-being of mankind than the limitation of population growth," says John D. Rockefeller 3d, chairman of the board of trustees of the Population Council, in the introductory chapter of this book, presented as part I. He lists four elements of change that offer reason for hope for action on the population problem: (1) recognition of the existence of the population problem by government officials, religious leaders, and private citizens; (2) discovery that ordinary men and women wish to limit the number of children they have; (3) improved technology of contraception; and (4) significant action on family planning in a number of countries.

In part II government officials and demographers report on the status, problems, and accomplishments of family planning programs in 13 countries—Japan (where the abnormally high postwar birth rate of 34.3 births per thousand population in 1947 was cut to 17.2 by 1957 and has remained at about that level ever since), South Korea, Taiwan, Malaysia, Singapore, India, Pakistan, Turkey, Tunisia, Puerto Rico, Jamaica, Chile, and the United States. In part III experts in various fields discuss family planning programs for the postpartum woman, medical education in relation to population control, modern methods of birth control, cost and operation of family planning programs, and population surveys. Part IV describes the international advisory services provided by American foundations, the International Planned Parenthood Federation, Sweden, and the United States.

In part V the editor, who is president of the Population Council, suggests that if family planning is widely accepted and birth rates are reduced substantially, pervasive social changes—including the improved status of women—will follow. In discussing population stabilization, he says, "The world may not be able to 'solve' the population problem in the next generation, but it does appear to be on the road to ameliorating it."

SOVIET PRESCHOOL EDUCATION, Volume I: program of instruction. Volume II: teacher's commentary. Translated from Russian by Educational Testing Service, Henry Chauncey, editor. Introduction by Urie Bronfenbrenner. Holt, Rinehart and Winston, Inc. New York, N.Y. 1969. Vol. I, 182 pp., $2.95, paperback; Vol. II, 218 pp., $4.95, paperback.

Volume I is an English translation of a 1965 revision of a manual for the operation of kindergartens published by the Ministry of Education of the Russian Republic, U.S.S.R. It contains a program for "character education" developed in 1962 by a joint commission from the academies of pedagogical and medical sciences.

According to the preface, "The objectives of the [kindergarten] program have been designed to be realized in the course of all children's activity—in play, in regular activity periods, in the routine of daily life, and in forms of work within the capability of the children." The manual gives the basic content of the kindergarten program, discusses the objectives of care and instruction for children in each of the first 7 years of life, describes characteristics of children at different ages and gives directions for organizing life in the kindergarten. Model daily schedules are presented in an appendix.

In an introduction to this English edition, Urie Bronfenbrenner, professor of early childhood education at Cornell University, says: "Whatever else one may think about Soviet methods of education, it is clear that the Russians have worked hard to develop ways for teaching their children, early in life, the values and *behaviors* consistent with Communist ideals." He lists eight distinctive qualities of Soviet education: character education; face-to-face interaction between infants (who are in group playpens) and staff members; carefully designed continuity of experience from kindergarten through school and communist youth organizations; development of collective consciousness; emphasis on children working together; emphasis on self-reliance; a "group adoption" program in which older children and adults work with a kindergarten class; and the subordination of the parents to the institution.

Dr. Bronfenbrenner points out that the Soviet kindergarten system serves more than 10 percent of all Soviet children under 2 years of age and about 20 percent of those between 3 and 6 years of age.

The second volume contains operating instructions and guides for preschool teachers.

BRIEF AND EXTENDED CASEWORK. William J. Reid and Ann W. Shyne. Foreword by Helen Harris Perlman. Columbia University Press, New York, N.Y. 1969. 270 pp. $7.50.

Planned short-term casework service is proposed by the authors of this book as the main treatment modality for family counseling agencies serving intact families who voluntarily seek help on child-related and marital problems. On the basis of unexpected findings from a 4-year experimental project begun in 1964 at the Community Service Society of New York City, William J. Reid and Ann W. Shyne suggest a reversal of the current practice of assigning extended open-ended service to most clients.

The authors report that 60 intact middle-income families who had received only eight interviews after intake made more progress in alleviating interpersonal problems than 60 similar families who had received service for up to 18 months. Moreover, the gains made by families who received brief service proved as durable as those achieved by families who received extended service, according to a followup study conducted 6 months after the end of service.

Cost-effectiveness is the major advantage of planned brief service, the authors say; the eight-interview form of service costs only about one-third as much as the extended form. The authors suggest that time limitations may have forced both the caseworker and the client to concentrate on immediate, resolvable problems, thus providing motivation for change.

THE LIVES OF CHILDREN: the story of the First Street School. George Dennison. Random House, New York, N.Y. 1969. 309 pp. $6.95.

How children from a low-income neighborhood on the Lower East Side of New York City responded to an elementary school program that allowed them freedom to follow their own interests is described in this book by one of the part-time teachers at the First Street School. A private school, supported by a foundation grant from 1964 to 1966, the First Street School based its program on the concepts of freedom and respect for each child demonstrated at A. S. Neill's Summerhill School in England, with an orientation to urban poor children. During its 2 years of operation, the school's enrollment of 23 consisted of almost equal numbers of black, white, and Puerto Rican children.

Many of the 9-, 10-, and 11-year-olds who attended First Street School had been considered "problem children" in public schools, because they were not performing at their age level or they were rebellious, liars, thieves, or nonconformists, according to the author. Almost all of the children improved markedly, and some few spectacularly, the author reports. Such improvement was not "simply a matter of learning, but of radical changes in character," he says. "As the months went by, the children who had been truants now attended eagerly, and those who had been failing now began to learn."

The author lists some unusual features of the First Street School, including its small size and low teacher-pupil ratio; its cost—about the same per child as the $850 annual operating cost of the New York City public schools; the kind of freedom experienced by teachers and pupils alike—unencumbered by formal tests, compulsory attendance, report cards, or even school administrators; and the teachers' dedication to the idea that a school is an environment for growth, with the relationships between children and teachers being at "the very heart."

guides and reports

INDUSTRY RELATED DAY CARE: the KLH Child Development Center: Part I. David F. Hawkins, Joseph R. Curran, John W. Jordan, and the staff of Social Administration Research Institute. Social Administration Research Institute, 629 Highland Avenue, Needham, Mass. 02194. 123 pp. $2.

Presents a case history on the establishment of an industry-based day-care center from 1965 to 1969.

MULTIPLY HANDICAPPED DEAF CHILDREN: medical, educational, and psychological considerations. McCay Vernon. Council for Exceptional Children, 1201 Sixteenth Street, NW., Washington, D.C. 20036. 1969. 124 pp. $3.75.

Presents the findings of a study of the incidence and prevalence of prematurity, rubella, meningitis, Rh factor complications, and heredity as causes of deafness in 1,468 multiply handicapped deaf children given preadmission evaluation at the California School for Deaf, Riverside, from 1953 to 1964 and the association of these diseases or disorders with other physical and behavioral anomolies in the children.

NEW DIRECTIONS IN PEDIATRIC SOCIAL WORK. Edited by Elizabeth Maginnis. Social Service Department, The Children's Hospital Medical Center, 300 Longwood Avenue, Boston, Mass. 1969. 34 pp. $2.

Contains five papers from the proceedings of the 50th anniversary celebration of the Social Service Department of the Children's Hospital Medical Center of Boston, Mass. Illustrates the daily practice of pediatric social work, describes its historical development within the institution, and presents a proposal for its educational future.

READINGS IN HOMEMAKER SERVICE: selected papers presenting the background, uses, and practices of homemaker-home health aide programs. National Council for Homemaker Services, 1740 Broadway, New York, N.Y. 10019. 1969. 221 pp. $3.

A compilation of selected papers, standards, and guidelines on homemaker-home health aide service programs, presented in six sections: philosophy and goals; patterns; standards; administration and financing; development of staff; and home-help services in other countries.

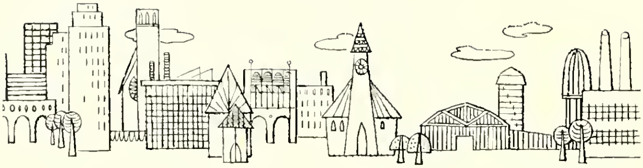
ACTION ON THE STREETS: a handbook for inner city youth work. Frank J. Carney, Hans W. Mattick, and John D. Callaway. Association Press, 291 Broadway, New York, N.Y. 10007. 1969. 160 pp. $4.95, clothbound; $2.95, paperback.

Reports briefly on the 6-year experience of the Chicago Youth Development Project of the Chicago Boys Club and the Institute for Social Research of the University of Michigan.

REFLECTIONS ON FOSTER CARE: a report on a national survey of attitudes and practices. Helen D. Stone. Child Welfare League of America, 44 East 23d Street, New York, N.Y. 10010. 1969. 40 pp. $1.

Reports the findings of a national survey of 482 public and voluntary agencies and institutions, including data on community structure for foster care, practice trends, factors affecting quality of foster care services, recent changes and innovations in practice, and length and cost of foster care.

HERE and THERE



School-age parents

Nearly 500 persons attended the National Invitational Conference on Parenthood in Adolescence, held in Washington, D.C., January 22–24 under the sponsorship of Yale University and the University of Pittsburgh in cooperation with HEW's Maternal and Child Health Service, Health Services and Mental Health Administration, and the Children's Bureau, Office of Child Development. The participants included administrators, physicians, educators, social workers, research workers, and nurses who are engaged in the provision of comprehensive services for school-age pregnant girls or whose work otherwise confronts them with the problem of teenage pregnancy. (See "Comprehensive Service Programs for School-Age Pregnant Girls," CHILDREN, September–October 1968.)

The purpose of the conference was to increase understanding of the circumstances that may lead to pregnancy in adolescence as well as of the problems faced by school-age parents and their child, of ways to improve services to school-age parents, and of possible methods of preventing parenthood in adolescence.

While attention was predominantly focused on the unmarried, speakers and discussants alike maintained that pregnancy and parenthood among adolescents under 16—whether married or unmarried—are a health, education, and social hazard. Joseph D. Beasley, M.D., of the Harvard Medical School, for example, pointed out that pregnant teenagers face a high risk of giving birth prematurely, which puts the infant at higher risk off suffering mental or physical impairment. He said that both maternal and infant mortality and morbidity are higher in teenage pregnancies and deliveries than in pregnancies in general.

As to social risks, Clark Vincent, Ph. D., of the Bowman Gray School of Medicine, Wake Forest University, pointed out that teenagers, who are still going through the search for identity, are often unprepared for the responsibilities of parenthood. Dr. Vincent also spoke of the "now" philosophy, widely espoused by young people today, and of the sexuality in the world around the adolescent, particularly in the mass media, as influences that lead to teenage pregnancies.

Among the "experts" who spoke of the personal problems producing and arising from pregnancy out of wedlock were 13 girls, ranging in age from 13 to 25, who knew of these problems from their own experience. Participating in a panel discussion at a general session, they variously named society, their parents, the schools, or "the streets" as at least partly behind the situation they found themselves in, but rarely—and then only indirectly—blamed the father of their child.

"It was revenge," said one girl telling of her futile efforts to please both parents when they were getting a divorce. Another said she had deliberately tried to have a baby to remind her of her boyfriend who was going to Vietnam. One mentioned a lack of a social worker for personal counseling.

views on prevention

Lack of sex education, either in the home or at school, and lack of information about contraceptives, however, were the girls' chief targets. These lacks also received a great deal of attention in the discussion groups, where viewpoints on contraceptives for teenagers ranged from the prohibitive to the permissive, the predominant middle view being expressed by those who would provide contraceptives to sexually active girls along with casework service to the girl and her parents.

Many of the conferees expressed the opinion that making contraceptives freely available would be the only way of stopping the upward trend in teenage out-of-wedlock pregnancies, but admitted to a concern lest such a policy be regarded by the young people as condoning extramarital sexual relations. Others spoke of a new culture arising among the young of which sexual expression is very much a part—"Sex is the thing now," as one young panel participant put it. And another young panelist said she saw nothing wrong in being pregnant because "I want the baby, my mother wants it, and my boyfriend really wants it."

major problems

In group discussions the conferees gave their major attention to problems of—

- How best to help school-age pregnant girls continue their schooling. Four alternatives were suggested, all admittedly with built-in problems: (1) the provision of special classes in the schools; (2) the provision of special classes in a special setting; (3) keeping the girl in her regular school class; and (4) transferring the girl to another school.
- How to prevent parenthood in adolescence, especially out-of-wedlock parenthood. Here the suggestions ranged from the provision of better counseling services, recreation, and job opportunities for young people, boys as well as girls, to the provision of contraceptives to teenagers—with or without parental consent—and the freer availability of abortions.
- How to help school-age parents who keep their babies provide a better quality of parenthood. Here a great deal of attention was given to school-age fathers, especially those who are members of minority groups. In addition to the need for counseling services for fathers, the conferees pointed to the need for broader employment opportunities for male members of minority groups, since lack of opportunities sometimes leads boys to feel that the only way open for them to prove their manhood is through sexual activity.

- What kind of special content to inlude in an educational program for the pregnant teenager—in relation to what s to happen to her physically, her child are responsibilities, her understanding f herself, and her motivation to complete her education.
- How to help girls interested in placng their babies for adoption find the appropriate resources. Here emphasis was put on the scarcity of adoptive homes for children in minority groups and the responsibility of social agencies o recruit more adoptive parents.

Following the conference some participants attended the first membership meeting of the National Alliance Concerned with School-Age Parents, an organization of persons associated with programs for school-age pregnant girls who are living at home. The association plans to promote the establishment of new comprehensive programs in various parts of the country.

New legislation

A 15-percent increase in social security benefits, effective for January 1970, is provided for in amendments to the Social Security Act under title X of the Tax Reform Act of 1969 (Public Law 91–172), which was signed by the President on December 30, 1969.

Under the revised schedule of payments, the average benefit for a single retired person increases from $100 to $116 a month; for a widow with two children, from $254 to $292 a month; and for a family made up of a disabled worker, his wife, and one or more children, from $237 to $273 a month.

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Child care centers for preschool and school-age dependents of labor union members may be financed through joint trust funds set up by employers and labor organizations, under an amendment of the Labor-Management Relations Act of 1947 signed into law by the President October 14 (Public Law 91–86). The law also authorized employers to contribute to joint trust funds that provide scholarships for employees, their families, and their dependents.

Payments from employers to union officials are illegal—except for specific fringe benefits mentioned in the law. Until the passage of the 1969 amendments, child care centers were not mentioned in the law.

The new law provides that employers and labor unions, by mutual consent, may include such trust funds in collective bargaining. It specifically provides, however, that no labor organization or employer shall be required to bargain on the establishment of a trust fund for such purposes.

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Rent set by public housing agencies may not exceed 25 percent of the income of a tenant in low-rent housing under the Housing and Urban Development Act of 1969 (Public Law 91–152), which the President signed into law December 24. The act provides, however, that this requirement shall not apply if such limitation will reduce the amount of public assistance that would otherwise be provided to the tenant by a public agency. The law also requires that if a Federally aided urban renewal project results in demolition of housing units for low- and moderate-income families, an equal number of such units must be provided in the area within which the local public agency has jurisdiction.

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Six States began the 1970's with laws that enable public agencies to provide subsidies for adoption to families who can meet a child's needs in all areas except financial. Legislatures in Illinois, Maryland, Michigan, and Minnesota passed adoption subsidy laws in 1969, a year after legislatures in California and New York. The laws are designed to provide permanent homes for those children who otherwise would be denied placement. This category includes some older children, some children with physical handicaps, some children of mixed races, and some family groups. In 1970 the legislatures in several other States will consider bills authorizing adoption subsidies.

Income maintenance

A program to provide cash payments to supplement incomes of all needy families and individuals, financed and administered by the Federal government, is proposed in a report submitted to President Richard M. Nixon in November 1969 by the President's Commission on Income Maintenance Programs. The commission was appointed 22 months previously by former President Lyndon B. Johnson to study the problems of poverty and of income in the United States.

As noted by the chairman, Ben W. Heineman, president of Northwest Industries, Inc., the basic structure of the proposal is similar to that of the family assistance program proposed by President Nixon last August. Both programs would provide assistance to the working poor as well as the unemployed poor with payments varying according to the size of the family. [See CHILDREN, September–October 1969, p. 205.]

In the commission's proposal, a single person with no other income would receive $750 annually and families with no other income would receive $750 for each of two adults and $450 for each additional member, whether child or adult. Thus a family of four with no other income would receive an annual payment of $2,400.

The commission recommends that benefit levels be raised "as rapidly as is practical and possible." It estimates that in the first stage the proposed program would cost the Federal government about $10 billion a year more than current assistance programs.

Under the proposal, families could retain 50 cents for each dollar of income that the family receives from work or other sources—a formula intended to encourage recipients to work. For example, a family of four could continue to receive a cash payment until its total income reaches $4,800.

The commission reports that in 1968 there were 25 million Americans whose incomes were below the Government's poverty index of $2.43 per person a day, or $3,553 per nonfarm family of four a year.

Calling existing governmental mechanisms and institutions "inadequate for alleviating existing poverty," the commission also recommends:

- The termination of Federal participation in existing public assistance programs.
- The establishment of a new locally administered program for temporary emergency assistance with Federal financial participation on a matching basis.
- The broadening of unemployment insurance programs.
- The phasing out of programs that provide food to poor families as equivalent assistance is given in cash.
- The improvement, consolidation,

and expansion of manpower and training programs.

• An expanded program of birth control information and services to all who want them.

The full report of the commission, "Poverty Amid Plenty: The American Paradox," is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (Price: $1.75.)

Oral contraceptives

Amid public controversy about the safety of "the pill," the Food and Drug Administration in January 1970 recommended to physicians that they discuss fully with their women patients the risks involved in taking oral contraceptives. In a letter to the nation's 381,000 physicians, hospital pharmacists, and hospital administrators, FDA Commissioner Charles C. Edwards, M.D., said that full disclosure of the potential adverse effects would permit the patient to participate in the decision of whether to use oral contraceptives.

At the same time, labeling requirements for oral contraceptives were revised to provide more information about safety and efficacy. Dr. Edwards urged physicians to familiarize themselves with the information, pointing out that in the United States an estimated 8.5 million women took oral contraceptives monthly during 1969. The "unsurpassed clinical efficacy of these products is well established," he said, although reported pregnancy rates vary from product to product, and sequential oral contraceptives appear to be less effective than combination oral contraceptives.

Potential risks from oral contraceptives, which are to be mentioned in the labeling material provided physicians, include various forms of blood clots. One study reported that such reactions are estimated to have occurred in 47 per 100,000 women who have taken the pill regularly, compared to 5 per 100,000 nonusers. Adverse reactions also known to occur in women patients taking oral contraceptives include nausea, vomiting, edema, migraine, rise in blood pressure, and other symptoms. A number of other adverse reactions—among them headache, nervousness, dizziness, loss of scalp hair, excessive growth of hair—have been reported, but the relationships have been "neither confirmed nor refuted." Physicians will be kept informed of the results of other studies in progress, the FDA commissioner said.

Also in January, a manufacturer withdrew a "mini-pill" oral contraceptive from field trials because it had produced breast cancer in some dogs. The mini-pill had been used in tests for about 2 years on about 3,000 women.

In another recent action, the British Committee on Safety of Drugs advised physicians in Great Britain to limit prescriptions for oral contraceptives to products containing 0.05 milligrams or less of estrogen, a female sex hormone. Reports from the tests on which this recommendation is based were not available for study by FDA in January.

White House Conference

The Seventh White House Conference on Children and Youth is to be held in two stages—the first to be focused on various aspects of child life and child development and the second on youth, according to an announcement by National Chairman Stephen Hess on January 6.

The conference on children is scheduled for the already announced dates, December 13–18, 1970. According to tentative plans it will include a number of regional conferences held simultaneously with the conference in Washington. The discussions will be based on recommendations of 30 to 50 panels of specialists in the areas of physical, mental, social, and religious development of children. Each panel will conduct a preconference study of a specific topic and will propose a program to solve some of the related problems through action by citizens, parents, voluntary agencies, and local, State, and Federal governments.

The second stage of the White House Conference, to be held in June 1971, will be planned and conducted largely by young people themselves. A major aspect of this stage will be displays showing the concerns that young people have about the society in which they live.

Outcome of pregnancy

A recently completed study of the outcome of pregnancies that occurred during a 3-year period in Kauai, Hawaii, has shown that by the time the surviving children were 10 years old, one third of them had developed physical, emotional, or intellectual difficulties; and that of all the conceptions that occurred in the designated period, half had resulted in death or damage from fetal or environmental causes either before birth or in the 10 following years. The study, which was sponsored jointly by the University of California at Berkeley, the Hawaii Department of Health, and later the University of Hawaii, was supported in part by the Children's Bureau. The principal investigators were Jessie M. Bierman, M.D., Fern French, Dr. PH, and Emmy Werner, Ph. D. of the University of California, and Angie Connor, M.D., of the University of Hawaii.

The study involved the observation of the outcome of nearly all conceptions that occurred in Kauai in which birth was expected during the years 1955 through 1957, from the time the expectant mothers missed their first menses until the surviving children were 10 years old. It also involved the assessment of the physical, intellectual, and social status of the children at preschool age and middle childhood. In all, 3,083 pregnancies were studied from which a cohort of 1,963 children were followed to age 2, and a somewhat smaller group to age 10.

The study investigators interviewed the pregnant women once each trimester, once postpartum, and again when the infant was 1 year old; they also studied the medical and hospital records and made ratings of the severity of any perinatal complications.

At the age of 2 years the children were given pediatric and psychological examinations. In addition to searching for congenital and acquired defects, the examiners appraised the children's nutritional status, feeding and sleeping habits, and speech and motor development. The assessment of the children at age 10 involved the collection of information from schools, physicians, hospitals, health departments, and parents.

The family environment of each child was assessed at age 2 and again at 10, an assessment that covered socioeconomic status, family stability, and an estimate of the mother's intelligence, based on years of schooling completed and a psychologist's impression gained from an interview. When the child was 10, the assessment also included ratings of the educational stimulation and emotional support received from his family.

Among other findings, the assessments of the children at age 10 showed the following results:

- The diagnosis made by age 2 for children with significant handicaps, physical or mental, or both, were largely confirmed. All these children had received diagnostic and treatment services during the intervening years.
- Among children with severe perinatal stress, IQ differences between those growing up in a favorable environment and those growing up in an unfavorable environment were much greater than the differences between children with and without perinatal stress growing up in a favorable environment.
- Ratings of socioeconomic status, the educational stimulation, and emotional support provided the child by the family correlated highly with ratings of the children's school achievement and intellectual and emotional status.
- More than 10 times as many children had problems ascribed to poor environment as had problems ascribed to serious perinatal stress.

The full report of the study will be published in 1970 by the University of Hawaii Press under the title, "The Children of Kauai—A Longitudinal Study from Conception to Age 10."

Child abuse

Of 34 children treated at the Children's Hospital of the District of Columbia in the latter part of 1963 for injuries suspected to have been caused by parental abuse or neglect, 14—or 41 percent—suffered further physical abuse or neglect during the 5 years after they were returned to their parents, according to a retrospective study carried out in 1968 by the hospital's department of psychiatry. Members of the study team were Larry B. Silver, M.D., Christina C. Dublin, and Reginald S. Lourie, M.D., the department's director.

The study involved 24 boys and 10 girls, who at the time they were first brought to the hospital ranged in age from 4 weeks to 15 years. Fourteen of the abused children required hospitalization. Two suffered permanent damage.

The study team reviewed all records on the children and their families in the hospital's social service files, the Women's Bureau of the Police Department, the Juvenile Court, the child welfare division of the District of Columbia Department of Public Welfare, and the Family and Child Service, a voluntary casework agency. It found that most of the families had a history of repeated abuse after the 1963 episode, that many families had had encounters with the police, and that 15 parents admitted their own involvement in the 1963 abuse episode or named a spouse or relative as the abuser. Responsibility for the abuse was attributed to the father in 22 cases, to the mother in 11, and to both parents equally in one case of chronic neglect.

All but two of the 34 cases had been referred by the hospital to the Women's Bureau at the time of discharge. Of these, 20 were subsequently referred by the Women's Bureau for protective service to the child welfare division of the public welfare department and one to the Family and Child Services. Four other families were already receiving protective services from the child welfare division at the time of the original episode of abuse.

Of the children who received protective services, eight were eventually removed from their homes through the Juvenile Court because of continued abuse or neglect. Of the seven children not referred for protective services, six were found to have suffered repeated abuse: one was brought back to the hospital dead 3 months after discharge; four were referred to the Juvenile Court; and the family of one was put under psychiatric observation. The only one of these seven in which recurrence of abuse was not reported was in a family in which the parents separated after the original episode so that the abusing parent was no longer in the home.

As a result of the study, the investigators concluded that no child who has suffered parental abuse should be returned to his family without protective service followup.

Education

To help children who have difficulty learning to read, the National Advisory Committee on Dyslexia and Reading Disorders, appointed in August 1968 by the then Secretary of Health, Education, and Welfare, has recommended a 3-year effort on the part of the Federal government to help the Nation's schools mount an effective program to prevent and remedy reading failure in children. Under the chairmanship of Arleigh B. Templeton, president of Sam Houston State University, Huntsville, Tex., the interdisciplinary committee spent a year examining the nature and extent of reading difficulties in children and preparing recommendations for dealing with the problem. Its report was released by Secretary Robert H. Finch on January 19.

The committee notes that 8 million children—or about 15 percent of the total elementary and secondary school population in the United States—experience difficulty in learning to read, although they seem to have adequate intelligence and emotional stability. These children come from all segments of society. The committee maintains that many children fail to read because of inadequate or unsuitable procedures by which reading is taught in schools. The committee lists the following factors that contribute to a child's inability to learn to read, in addition to inadequacy of instruction: mental retardation, neurological or sensory dysfunction, emotional disorders, and environmental deprivation.

Emphasizing the importance of achieving a coordinated approach to the problems of reading disorders, the report points out that basic information for building a national reading program is not currently available. The committee recommends the following preliminary steps for developing such information:

- Establishment of an Office on Reading Disorders in HEW. This office would coordinate a national effort in research on and development of reading programs.
- Establishment of a network of 10 to 20 Operational Reading Research and Development Centers. Such centers would be charged with answering specific questions that must be resolved before a national program to attack reading disorders can be started. Among the centers' assignments would be the development and testing of procedures that will identify preschool children who present a high risk of reading disorders, recognize the failing reader early in his school career, improve regular classroom instruction in reading, provide a remediation program for the failing reader, and develop standards of reading achievement to achieve comparability of reading performance.
- Expansion of training programs and grants for teachers of reading,

reading specialists, and research workers in the field of reading.

Single copies of the committee's report, "Reading Disorders in the United States," are available from the Information Office of the National Institute of Neurological Diseases and Stroke, National Institutes of Health, HEW, Building 31, Bethesda, Md. 20014.

Pediatric care

The physician's attention to the expectations of the mother of a child and the warmth of the doctor-patient relationship influence a mother's satisfaction and compliance with medical advice to a significant degree, according to a study made in Los Angeles in 1968 by Barbara M. Korsch, M.D., and two public health nurses, Ethel K. Gozzi and Vida Francis, with support from the Children's Bureau.

Eight hundred patient visits to the walk-in clinic, Children's Hospital of Los Angeles, were studied by recording on tape the verbal communication between the physician and the patient's mother, and by followup interviews with the patient's parents. The purpose was to identify those attributes of the doctor-patient interaction that were related to visit outcome, defined in terms of (1) the mother's satisfaction and (2) followthrough on medical advice. The sample consisted of first encounters between the mother and a designated physician who had at least 1 year's experience in pediatrics. Everyone involved knew of the presence of the tape recorder.

The study found that 76 percent of the patients were rated as being satisfied with their visit, while 24 percent were dissatisfied. Analysis of the data further indicated that—

- 53 percent of the satisfied patients followed their physician's medical advice as against 23 percent of the dissatisfied.
- The three types of expectations most frequently voiced by the mothers were: (1) to learn the diagnosis or the cause of the illness, or both; (2) to have their children receive shots, tests, or X-rays; (3) to be given medicine. Failure to have these expectations fulfilled was significantly associated with less satisfaction with the medical visit and less compliance with medical advice.
- The failure of the medical visit to fulfill other expectations—to have the child hospitalized, to have the child cured, to receive reassurance, to be given an explanation about the seriousness of the illness or instruction about treatment—was significantly associated with dissatisfaction, but did not affect the mother's compliance with the medical advice.
- The mother's perception of the physician as friendly or understanding was significantly associated with satisfaction and compliance, and the mother's perception of the physician as businesslike or not understanding was significantly associated with both dissatisfaction and noncompliance on the part of the mother.
- Discussion of cause did not influence followthrough with medical advice but lack of it led to dissatisfaction.
- The mother's race, education, or social class bore no relationship to outcome of the medical visits.

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readers' exchange

LIN-FU: *The root of the problem*

The excellent article by Jane S. Lin-Fu, "Childhood Lead Poisoning—An Eradicable Disease" covers comprehensively the preventive approaches to this most destructive problem. (CHILDREN, January–February 1970.)

I would like to discuss one of her points. From our experiences with the problem at the Children's Hospital in Washington, D.C., we have come to believe that attempts to enforce laws requiring landlords to correct the hazards from paint containing lead do not comprise the most effective preventive approach. Very often when complaints are made about the hazard, landlords put pressure on the families to move. In fact, moving is common among families in which lead poisoning occurs.

Therefore, we believe that the health worker's approach to the problem would best be directed to eliminating pica—the practice of eating nonfood substances. (See "Why Children Eat Things That are Not Food," by Reginald S. Lourie, M.D., Emma M. Layman, and Frances K. Millican, CHILDREN, July–August 1963.) As Dr. Lin-Fu indicates, pica is the basic cause of ingestion of lead-containing substances.

We have found that pica is usually a superficial symptom. In the early stages (particularly before brain damage occurs from the lead poisoning), it often responds readily to remedies directed at meeting the basic needs of the parents and children involved. We would suggest, therefore, that inquiry about the presence of pica be a routine question in health examinations, not only as a first step in detecting lead poisoning, but also for opening up a look at the factors in the family life that could underlie the symptom.

Reginald S. Lourie, M.D.
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Correction

Through an editor's error, a line in Dr. Jane S. Lin-Fu's article on lead poisoning in the January–February issue of *Children* gave the impression that all use of lead-based paint is illegal in most States. As Dr. Lin-Fu has pointed out, lead-based paint is still widely and legally used for many purposes. In a reprint of the article, available through the Health Services and Mental Health Administration, Maternal and Child Health Service, the line has been revised so that the sentence involved now correctly reads: "According to the 1960 Housing Census, 30.6 million of the occupied housing units in the United States were built in or before 1939, when lead-based paint was still commonly used for interiors in most States."

Copies are available from Maternal and Child Health Service, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852.

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ublications for which prices are quoted are for sale by the Superintendent of Docu-ents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be companied by payment. Twenty-five percent discount on quantities of 100 or more.

EGISLATIVE GUIDE FOR DRAFTING FAMILY AND JUVENILE COURT ACTS. William H. Sheridan. HEW, SRS, Children's Bureau. CB Publication No. 472. 1969. 57 pp. 35 cents.

Presents suggested language for local d State laws related to family and venile courts, with comments on the inciples that underlie the proposed gislation.

ROGRESS IN INTERGOVERNMENTAL PERSONNEL RELATIONS. Report of the Advisory Committee on Merit System Standards. HEW, Department of Defense, Department of Labor. 1969. 130 pp. 60 cents.

Presents recommendations for mak- g the Federal-State cooperative per- nnel program more effective in trans- ting social purpose into action.

TATE SALARY RANGES: July 1, 1969. HEW, Office of State Merit Systems. 1969. 44 pp. Single copies free from the Office of State Merit Systems, Department of Health, Education and Welfare, Washington, D.C. 20201.

Presents results of a survey of salary ranges for selected classes of State and local positions in employment security, public welfare, public health, mental health, vocational rehabilitation, and civil defense.

PREPRIMARY ENROLLMENT OF CHILDREN UNDER SIX: October 1968. Roy C. Nehrt and Gordon E. Hurd. HEW, Office of Education, National Center for Educational Statistics. 1969. 17 pp. 30 cents.

Reports on the number of children from 3 to 5 years of age enrolled in early childhood education programs in the United States in October 1968, giving enrollment rates by age, as related to family income, occupation of family head, and residence.

PERSPECTIVES IN PUBLIC WELFARE: A History. Blanche D. Coll. HEW, SRS, Office of Research, Demonstrations, and Training. Intramural Research Division. 1969. 107 pp. 70 cents.

Traces in detail ideas and programs regarding public welfare in the United States from the 17th century to the 1930's, with emphasis on the persistence of public assistance as the principal method of caring for the poor, the persistence of criticism of this method, and the current scrutiny and reappraisal of public welfare policy.

DELINQUENCY TODAY: a guide for community action. HEW, SRS, Office of Juvenile Delinquency and Youth Development. 1969. 22 pp. 20 cents.

Presents on overview of the problems and concepts of juvenile delinquency and offers a suggested blueprint for community programs to deal with the problem.

FIRE! FIRE! LOOK OUT! IT BURNS! HEW, SRS, Children's Bureau. CB Publication No. 470. 1969. 12 pp. 15 cents.

Suggests ways parents can help prevent fires in their homes and accidental burning of their children by teaching the dangers of fire and correcting fire hazards in their homes.

EW refers to Department of Health, ducation, and Welfare; OCD, to Office f Child Development; SRS, to Social nd Rehabilitation Service.

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Infant Mortality: Issues and Trends

Adoption in One-Parent Families

Using Houseparents' Creativity

Service Pattern for Pregnant Teenagers

VOLUME 17 • NUMBER 3 • MAY–JUNE 1970

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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This alert baby is a statistic only in birth records, and fortunately not in those grimmest of all records, infant mortality statistics, the subject of two articles in this issue. In contemplating vital records of any kind it is easy to lose sight of the fact that each digit in the computations involved may represent great joy or sorrow to someone. As pointed out on page 89, a continuation of a recent acceleration in the downward trend in U.S. infant mortality rates can mean that the lives of nearly 15,000 infants are spared in 1970.

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INFANT MORTALITY

an urgent national problem

FRANK FALKNER

The infant mortality rate of the United States, the richest country in the world, ranks 13th among the rates of countries with reasonably reliable data.[1] The infant mortality rate is the number of infant deaths in the first year of life per thousand live births. In 1968, the latest year for which figures are available, the rate was 21.7. In parts of the United States, however, the rates are much higher and are clustered in large urban areas and in poverty-ridden sections throughout the country. Such high rates indicate that the health of mothers and babies in this country is needlessly and grossly jeopardized.

On a worldwide basis infant mortality rates among recording countries range from an awesome 200, or even 500 in some segments of populations, down almost to 12. Moreover, in many of the less affluent countries many births and deaths go unreported. For example, it has been estimated that 1 million live births and subsequent deaths occur in India each year that are not recorded.[2]

Yet with all our affluence in medical, physical, and professional resources in the United States, we have to accept the fact that 12 countries (including France, Eastern Germany, Switzerland, and Japan as well as the Scandinavian countries) have lower infant mortality rates than we do.

Much has been written about whether comparisons between countries' infant mortality rates are valid or whether it is fair to compare the high rate in the U.S. with Sweden's, which in 1967 was 12.9, the lowest rate reported for that year to the United Nations. The validity is questioned since Sweden has a small population, a high standard of living in all social classes, and a national health service. But these differences are exactly the reasons the figures of the various nations should be compared. *How* does Sweden achieve such an admirably low rate? Careful examination of all the factors involved, and assessment of their relative importance, will lead us not only to self-examination, but will indicate the priorities for attack.

Some medical people say that comparisons between United States and Swedish figures are not valid because in Sweden "a birth need not be reported until up to 5 years after the event." [3] This statement has no basis in fact. All births and deaths in Sweden must by law be reported within 24 hours. Moreover, epidemiologists are careful to examine all the facts when international comparisons are made to find out whether adjustments or care in drawing conclusions may be necessary. Even if the statement were true, however, there would still be a basis for comparison. In Sweden, 98 percent of the births occur in hospitals, a situation that allows of reliable data collection.

Reporting of accurate data, collection of such, and definitions are obviously important if international comparisons are to be statistically sound. Some countries—particularly the developing countries—do not have the wherewithal to collect accurate figures. We guess at their infant mortality rates as best we can. But largely owing to standards set by the World

Health Organization, many countries of significant size and variation do collect and report their data in such a way as to make comparisons generally valid and proper.

Some countries are said to consider a baby who does not live for 24 hours as stillborn, and it is sometimes implied that this birth would be reported as live in the United States of America.[3] But would it? The United States has many rural and underprivileged urban areas where similar births are regarded as stillborn and where data is thus suspect. Were data in such areas accurate, it is virtually certain that our own infant mortality rate would be higher than our present estimate. This of course would also be true in some other countries.

There is another point involved. The infant mortality rate in the United States has indeed been improving, but only very slowly, in the last 15 years. The slope of decline is virtually the same in many countries other than the United States even though their rates may be better or worse than ours. But the annual rate of improvement has been faster in other countries than in the United States.

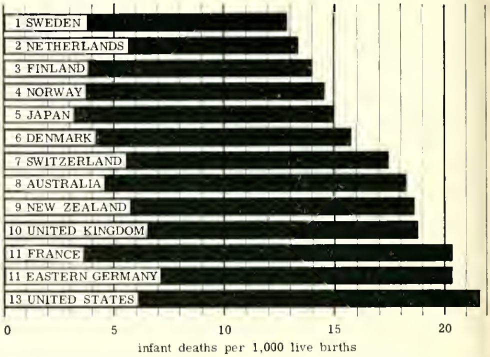
Analysis shows that the decline in infant mortality rates in Sweden in the past two decades has been due primarily to a decrease in deaths after the first week of life and also after the first month of life. While Sweden's rates are lower than any other country's, the pattern of decline is similar in many countries, including the United States, where a virtual plateau has been maintained since about the mid-1950's. But in Sweden the plateau has occurred at the low rate of approximately 13. It is made up of the rock-bottom etiological stumbling blocks to further reductions: congenital malformations, birth injuries, and respiratory disorders. These causes account for 50 percent of the infant deaths; unqualified immaturity accounts for 25 percent; and unknown causes for the remaining 25 percent. In Sweden, for low-birth-weight babies the perinatal mortality rate—fetal deaths and deaths in the first 28 days of life—is about 20 times that of normal-weight newborns.

Vigorous research and cooperation with other countries is necessary to uncover such common obstacles to improvement.

The U.S. picture

Now to look at the picture in the United States. The rate decreased from 100 in 1915 to 25 in 1965, with the greatest decrease occurring during the early part of the 20th century. Beginning in 1950, the decrease slowed considerably and the plateau appeared. Between 1955 and 1965, the infant mortality rate decreased by only 6 percent, or less than 1 percent per annum.[4] Between 1955 and 1960, only three of the largest cities in the United States had any reductions in infant mortality.[5]

INFANT MORTALITY IN COMPARABLE NATIONS
as reported to the United Nations in 1968



Source: United Nations Demographic Year Book, 1968. The rates represented are for 1967, except those for the following countries: Finland, New Zealand, United Kingdom, France, Eastern Germany, and the United States, which are for 1968; and the rate for Norway, which is for 1966.

Of the 34 countries with rates below 50 in 1963 and 1964, the United States had the least favorable reduction during the preceding 5 years, with one exception.[2] The improvement, such as it was, seems to have been centered in urban areas.

Improved services in urban areas may be reflected in some reductions in rates. Urban rates have in recent years been coming down much more rapidly than in the Nation as a whole: reductions of deaths among black infants are greater than those among white infants.

Preliminary figures for 1968 are not encouraging; the rate of decline seems to have been somewhat under 2 percent as opposed to 5 percent in 1967. In the most important period of all, the first year of life, the risk of death is still higher than in all other periods before the age of 65.

It is important to eliminate once and for all an incorrect assumption drawn both here and abroad: that the major reason for the high infant mortality rate in the United States is the well-known fact that the infant mortality rate among black babies is double that among white babies. The assumption is that the relationship of the black population with the poverty cycle is what is holding everything up and causing the problem. The assumption is inaccurate and misleading. Since only 15 percent of the U.S. population consists of black people, were that part of the population excluded from the rates, the U.S. infant mortality rate for 1967 would be only two points lower—20 instead of 22. There are, in fact, some indications that poor white families may have higher infant mortality rates, at least in some areas. Racial factors are the least of the problem as far as the overall high infant mortality rate is concerned. We have known for a long time that the death rate among low-birth-weight babies is especially high, but we are still not sure what factors contribute to this problem. The greater risks of death for low-birth-weight babies than for babies of normal weight are not limited to any one socioeconomic level. This points up the necessity to attack not only environmental, social, and economic problems associated with infant mortality but also the biological problems.

Some priorities

Modern, sophisticated biometric methods in some countries show promise of delineating two major groups of infants involved in infant mortality and approaches to a broad solution. The mortality rate needs to be reduced for babies of all birth weights, who can be considered as one group. But the most vulnerable group, babies of low birth weight, accounts for the largest part of the rate, which should have priority for reduction. This calls for concentration on the *prediction* of high-risk infants and the provision of special prenatal care and highly skilled care for mother and infant during the birth process and in the immediate postnatal period.

There is a vital need for many of the disciplines involved in providing health services to mothers and infants to work closely together to bring about significant improvements. The recent rise in standards of training and excellence in neonatology, that branch of pediatrics concerned with the newborn, should not give obstetricians the impression that the neonatologist can achieve success in the care of the newborn baby irrespective of the baby's condition or weight. All the factors involved in insuring optimal health of the mother during her childbearing years and especially during pregnancy are of the greatest importance, for they determine whether intact or damaged babies develop.

The macroscopic view of the problem obtained from the routine analysis of statistics is available for all to see. Much can be gained by more cogent anlysis, or the microscopic view obtained from the intensive study of individual infant deaths from representative samples.

Two key points must be stressed:

1. We need to concentrate not only on reducing infant mortality but even more on assuring that children who survive are whole and healthy. The often-forgotten morbidity of the saved, yet damaged child needs particular attention. Once an infant survives for a full year he escapes from ever being an infant mortality statistic. But is he intact? Is he healthy?

2. It is fallacious to argue about whether the quality of medical care or the child's environment is the more important factor in relation to infant mortality. These factors cannot be separated. No matter how good the medical care system is, mortality rates cannot be lowered below a certain point unless changes are made in the social environment, such as improvements in housing, income, and the quality of education available to the poor.

Some salient points

Both research and corrective action are needed to improve the chances for life and health for infants born in this country. Such improvement would inevitably show up in a reduction in our infant mortality rate. An effective plan of attack, however, will require attention to the following points:

- ***The irreducible minimum for the infant mortality rate is not known.*** In this country about 30 percent of

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Lively and healthy, this newborn has a life expectancy of 75.1 years. Nevertheless until she passes infancy she will be in the most dangerous period of life before the age of 65.

the babies who live at least a week but less than 1 year die of infections. This part of the infant mortality rate can clearly be reduced. But the greater part of the infant mortality rate is accounted for by infants who died during the first week of life, and therefore this is the part in which the principal reduction will have to be made. We do not know what the lowest possible rate may be nor how to achieve it.

- *Deaths in the first week of life account for two-thirds of all infant deaths,* according to 1966 figures.[4] That year, out of a total of 85,000 infants who died before they were 1 year old, 56,000 died within their first week of life. About two-thirds of deaths in the first week occur in babies with birth weights of 2,500 grams or less. Births of premature and low-birth-weight babies have *increased* about 8 percent in this country since 1950, when national statistics on birth weights first became available.[6,7]

Thus, the causes of low birth weight and short gestation period are fundamental issues in our infant mortality rate.

- *The etiology of premature birth can be explored* by looking not only at the quality and availability of health services, but also at the biological, social, and economic environment in which the baby is conceived and carried. The greatest efforts must be focused on the environmental factors that affect the baby's ability to survive his first week. This calls for vigorous examination of such factors as pregnancy intervals, age of mother, parity, the onset of labor, and the state of maternal nutrition—all factors in "maternal biology," to invent a phrase.

- *The disadvantaged have higher infant mortality rates and a higher proportion of low-birth-weight babies* than the population as a whole. However, there is a tremendous variance among different subgroups of the disadvantaged population. The problem is not tied to race. Infant mortality rates are different in different parts of the same city; adjacent counties in a single State have significantly different rates unrelated to race and socioeconomic background.[8] We need to discover what must be changed for each subgroup of the population, whether changes in the system of care will produce desirable results, or whether the total social and economic environment of such groups must be changed.

- *The relief of social and economic disadvantages* would have a major effect on infant mortality. Problems of poverty, nutrition (including promotion of breast feeding), sanitation, education, home and family conditions, and illegitimacy require concentrated attention. Organization of resources to deal with these problems can appreciably reduce the incidence of low birth weight, mortality, and morbidity among infants. Of all the factors involved, the nutrition of families is the one most amenable to immediate improvement, but a national commitment is required to attain this goal.

- *Intervention to change a predictable and undesirable course of events can occur at many points* over a long span of time, beginning as early as the childhood of the mother. Astonishingly little is known, however, about ways of controlling the factors in fetal and early childhood development or why specific factors have the effects they do. For many babies there is a brief critical period just after birth that can make the difference between life and death or between intact survival and a damaged child. The crucial need is to prevent such neonatal crises from occurring by insuring fetal excellence. Attention must be given not only to secondary prevention through highly skilled, intensive neonatal care, but also to primary prenatal prevention through highly skilled antenatal care, including when necessary intervention to avert a predictable event, such as the effects of RH incompatibility in mother and child.

- *The effectiveness of various methods of intervention can only be evaluated by long-term studies* that bridge the generations. While dramatic changes in infant mortality rates have occurred in areas where there are services providing comprehensive maternal and infant care and intensive neonatal care, such services may not represent the whole answer to the problem. Improved methods of caring for the fetus, for example, may yield even greater returns, particularly in terms of intact survival.

- *Priorities for intervention have to be set, for resources are limited,* even in a wealthy country. Two goals, however, are essential: (1) Bringing about changes in the social structure to eliminate underlying socioeconomic problems in infant mortality and morbidity—a long-range preventive goal; and (2) bringing about an immediate decrease in neonatal deaths and an increase in intact survival by making intensive obstetric and neonatal care available to all who need it. Infant mortality rates can be reduced rapidly by 40 to 60 percent in parts of the United States where they are lamentably high, through application of present knowledge and through the expansion of comprehensive maternal and child health services.

- *Provision of staff to plan and carry out such services will require an extensive program of training.* There is not only the need to train more people for health services and more types of health manpower, but also the need to train members of the overall health team in totally new ways.

- *Family planning can have an indirect effect on infant mortality* because it promotes and protects family health through better spacing of children. It can reduce the number of pregnancies among very young women (among whom the incidence of premature delivery is high), women beyond the peak childbearing years, those who are ill, and those who will be poor mothers because they do not wish to have children. The whole area of maternal biology as a backdrop to birth of intact, healthy newborns needs careful review and further investigation. Such investigation should include study of and attention to the female during the entire development age span before and throughout the childbearing years.

- *All key factors involved in infant mortality contain elements in need of further research.* Many of the recent reductions in infant mortality rates are directly attributable to the results of research on such problems as respiratory distress among newborns, asphyxiation, and RH-negative blood factors.[9] Similar work needs to be carried out in other areas—for example, the sudden infant death syndrome and the effect of malnutrition on fetal development.[10] Probably even more important is the need for controlled evaluative and epidemiological studies, using the microscopic, rather than the customary macroscopic, approach to determine the specific etiological factors in infant mortality and the effectiveness of various forms of biomedical intervention.

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[1] United Nations demographic yearbook, 1968. United Nations, N.Y., 1969.

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[8] Bill, H. E.: Preliminary analysis of perinatal mortality; 31 hospitals which had 2,000 or more white deliveries, 1964–66. Personal communication, 1969.

[9] Lin-Fu, Jane: New hope for babies of Rh negative mothers. *Children,* January–February 1969.

[10] Dayton, Delbert: Early malnutrition and human development, *Children,* November–December 1969.

INFANT MORTALITY TRENDS and MATERNAL and INFANT CARE

ELEANOR HUNT

Infant mortality is an important health indicator in the broad area of maternal and child health. Because of the frequent association between infant mortality rates and social factors, excessive rates may serve to identify neighborhoods and larger areas that have a high incidence of such social handicaps as overcrowded housing, limited education, high fertility, premature births, births out of wedlock, and other disadvantages. Estimates of trends in infant mortality rates during 1956–65 and in the subsequent period 1965–68, in the United States as a whole and in each State (except for Alaska and Hawaii but including the District of Columbia) have been made recently in a special maternal and child health study, supported by the Children's Bureau.[1]

When the States are grouped according to similarity of trends, a relationship appears between reduction in rates and the strengthening of services for maternal and infant care.

In the study the slope of the trend of the infant mortality rate was determined on the basis of the annual average percent change in rate.

During the decade 1956–65, the percent annual reduction in the U.S. infant mortality rate amounted to less than 1 percent (0.8 percent). In isolated semirural and rural counties where about 18 percent of all live births in the United States occur and the infant mortality rate is at least 10 percent above national average, the annual percent reduction in rate over the same decade was below national average: 0.6 percent in isolated semirural counties and still lower in the isolated rural counties.

The slow pace of reduction of infant mortality at the national level reflected lack of progress in many of the States. Of the 49 States studied 27 had essentially stationary rates in the sense that changes in rate during the decade could be explained on the basis of chance fluctuations. In the subsequent years, 1965–68, 14 of the same States continued to have mere fluctuations in rate without any significant trend (group A). In contrast, the remaining 13 of the 27 States recorded significant downward trends during 1965–68 despite their essentially stationary rates in the preceding decade (group B).

Of the 22 States that in 1956–65 made significant

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States Grouped According to Infant Mortality Trends 1956–65 and 1965–68

Group A:

Essentially stationary trends in both periods: Arkansas, Connecticut, District of Columbia, Illinois, Iowa, Montana, Nebraska, New Hampshire, Oregon, Rhode Island, South Dakota, Vermont, Wisconsin, Wyoming.

Group B:

Essentially stationary trends 1956–65 followed by significant annual percent reductions: Alabama, Delaware, Georgia, Idaho, Indiana, Louisiana, Mississippi, Missouri, New York, North Carolina, South Carolina, Tennessee, West Virginia.

Group C:

Significant percent reductions during 1956–65 not continued subsequently: Arizona, Colorado, Florida, Kansas, Kentucky, Maine, Massachusetts, Minnesota, Nevada, New Mexico, North Dakota, Oklahoma, Pennsylvania, Utah, Washington.

Group D:

Significant annual percent reductions in both periods: California, Maryland, Michigan, New Jersey, Ohio, Texas, Virginia.

rogress in reduction of infant mortality, 15 failed o sustain a significant pace of reduction during 1965–8 (group C). The remaining seven States (group) were characterized by a continuing downward rend in the infant mortality rates during 1956–65 nd also during 1965–68, with a noteworthy increase n pace of reduction.

An increasing proportion of white infants among otal births in the five States of group B was probbly a factor in their accelerated decreases in infant ortality rates. States in this group that had an ncreasing proportion of white infants were Alabama, eorgia, Mississippi, North Carolina, and South arolina.

An 0.8-percent reduction in the U.S. infant morality rate during 1956–65 provides an estimated U.S. ate for 1970 of 23.7. However, based on the experince of 1965–68—which brought the rate for 1968 to 1.7—the estimated annual percent reduction has increased fivefold from 0.8 percent per year (1956–65) to 4.4 percent.

If the 1965–68 trend continues, the infant mortality rate in 1970 will be the lowest U.S. rate so far attained, 19.8. If the 4.4 percent per year reduction is sustained during 1969 and 1970, the lives of 25,653 infants will have been spared: 11,020 in 1969 and 14,633 in 1970.

Current provisional U.S. rates provide evidence of continuation of the more rapid rate of reduction beyond 1968. Table 1 shows provisional annual rates for 1965 through 1969 and the percent reduction in rate. Year to year percent decreases in rate are not directly comparable with an estimated slope of a trend over a period of years. Nevertheless, these annual decreases do illustrate that (1) in the United States infant mortality evidently declined more rapidly after 1965 than in the previous decade, and (2) on the basis of provisional figures, this pace of reduction has continued with some fluctuation through 1969.

Maternity care

Toward the close of the period 1956–65, maternity and infant care projects, financed up to 75 percent of cost by the Federal Government, were authorized by the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to title V of the Social Security Act.[2] By 1968 there were more than 50 such projects operating in large- and medium-size cities as well as in rural areas. All of the projects have the same aims: improvement of maternal health and reduction of birth defects through high quality, com-

Table 1.—Provisional Infant Mortality Rates, United States, 1965–69

Year	Rate per 1,000 live births	Percent reduction from previous year
1965	24. 8	-----------
1966	23. 4	5. 6
1967	22. 1	5. 6
1968	21. 7	1. 8
1969	20. 7	4. 6

Source of data: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Center for Health Statistics, Monthly Vital Statistics Report. Provisional Statistics, vol. 18, no. 12, Mar. 12, 1970, and corresponding issues for preceding years.

Table 2.—Distribution of Maternity and Infant Care Projects, Fiscal Years 1965–68

State groups	Number of States	Number of projects	Number of projects	Average years in operation
	Total	Total	Per State	Per State
All groups	49	52	1.1	1.9
Group A	14	7	.5	1.4
Group C	15	17	1.1	1.7
Group B	13	18	1.4	2.0
Group D	7	10	1.4	3.0

Groups B and D, which have more projects per State than Groups A and C and whose projects have operated for longer periods, had the most noteworthy annual reductions in infant mortality rates since 1965. (See chart p. 89.)

prehensive maternity and infant care, including child-spacing services. The services are provided in areas with concentrations of low-income families, where fertility, prematurity, and infant deaths have high frequencies.

During fiscal years 1965–68, total annual expenditures of Federal, State, and local funds for special projects for maternal and infant care increased from $4,864,000 in fiscal year 1965 to $47,687,000 in fiscal year 1968. In the same years, but beginning as early as 1962, the federally aided State maternal and child health programs were notably strengthened.

Federal, State, and local expenditures per mother and infant for maternal and child health programs and for special maternity and infant care projects in the United States as a whole, considered jointly, and with allowance for increase in prices, amounted in fiscal year 1965 to $13.90 (constant dollars)—a 78 percent increase over the $7.82 spent per mother and child in fiscal 1956. In the 3 years following fiscal 1965 the expenditure in constant dollars per mother and infant rose more rapidly than in the preceding decade: from $13.90 in fiscal year 1965 to $19.45 in 1968—an additional increase of 71 percent in only 3 years.

Also during these 3 years neighborhood health centers, supported by the Office of Economic Opportunity, were established by local groups that reached out to find needy patients in deprived urban and other neighborhoods.[3]

In addition, Medicaid, established under title XIX of the Social Security Act, as amended in 1965, has provided medical assistance for the needy and medically indigent since 1966. About 25 percent of expenditures for medical assistance in fiscal year 1968 was for recipients eligible on the basis of membership in a family with dependent children under 21 years of age.[4] Figures showing how much obstetrical and pediatric care has been provided through Medicaid are not available.

Because of a lack of adequate data, at present it is not possible to tell whether or how much each source of service has affected the infant mortality rate. However, the distribution of special maternity and infant care projects among the four groups of States described does suggest that the presence of such projects in a State helped increase the annual percent reduction of the State's infant mortality rate during the period 1965–68. Groups B (13 States) and D (7 States), in which the States made the most noteworthy progress, were the groups that in those years had the largest number of projects per State. Moreover, at the close of fiscal year 1968, the projects in State groups B and D had been in operation longer on the average than those in groups A and C—2 and 3 years as compared with 1.4 and 1.7 years. (See table 2).

Nevertheless, even if the recent annual 4.4 percent reduction of infant mortality in the United States is continued, it is not adequate to achieve during the 1970's a national rate as low as that of Sweden's in 1967—12.9. To approach this level by 1975, the annual percent reduction in the U.S. rate needs to be accelerated to an estimated 7 percent.

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[1] National and State trends in infant mortality: 1956–65 and 1965–68. Demographic and operational analysis of maternal and child health. George Washington University, Washington, D.C. (In press.)

[2] Close, Kathryn: Giving babies a healthy start in life. *Children*, September–October 1965.

[3] Lesser, Arthur J.: The Federal Government in child health care. *Pediatric Clinics of North America*, November 1969.

[4] U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, National Center for Social Statistics, NCSS report B–5, Medicaid. Fiscal year 1968.

black mothers speak and a white teacher listens

SYLVIA CLIFFORD KUNREUTHER

Recently public school educators have been forced to reexamine their relationships with local communities. Students and parents have complained that the traditional approaches—PTA, parent discussion groups, conferences—have not allowed for meaningful dialogue between school personnel and the families they serve. These problems are even more difficult in black communities, where white middle-class teachers and principals are not in tune with the customs of the people with whom they work.

For a teacher to be effective in her classroom, especially in a preschool, she needs a working relationship with the parents of children she serves. The teacher needs to understand that parents, after all, are their children's first teachers, and their approach to the teaching-learning process may be different from hers.

The attitudes that parents convey to their children in regard to school are greatly influenced by their own school experiences, which have often been experiences of failure. Too often the lack of communication between teachers and parents aggravates the parents' negative attitudes toward the school. But if the teachers communicate their concern, sensitivity, and questioning spirit to the parents, then the parents may transmit more positive feelings to the children.

In an effort to develop meaningful dialogue between the parents of some preschool children in a black inner-city neighborhood, eight mothers and I—their children's white preschool teacher—met weekly during the school year 1967–68. Tapes were made of the discussion sessions and through reviewing these, a clinical psychologist, James Hill, helped me understand what went on during the group process and my own role in it. The demonstration was part of a larger project to determine ways of sustaining children's interest in learning, being supported by the Kenneth F. Montgomery Charitable Foundation in collaboration with the Institute for Juvenile Research. What I shall call "the listening approach" was the major thrust of the parent-teacher program and the means by which the mothers and I grew to understand one another.

The Dr. Martin Luther King, Jr., Family Center (formerly Henry Horner Preschool) is situated in four contiguous apartments of a public housing development on the near west side of Chicago. All of the children served in its preschool live in this development. The eight mothers in the parent-teacher program were considered to have the most competent children in the total preschool enrollment of 40 children. They tended to have a better command of language than the average mother with children in the preschool, although they did not differ in age, education, or income. Their children represented what staff members regarded as "typical 4-year-olds"—more mature emotionally, socially, and in the use of language than the other children in the center. This judgment was made on the basis of three independent observations: by a teacher in the classroom, by a social worker in the home setting, and by a psychiatrist in a play session.

The group

I explained to each of the mothers in the selected group that it was important for me to get to know her so that I could work more effectively with her child in the preschool. I told the mothers that I wanted to have weekly seminars for the entire school year as a part of my preschool program. All the mothers accepted the invitation and came regularly to the meetings, except one who had a full-time job.

We met every Tuesday around 10 a.m. for about an hour and a half in the center's parent and staff lounge, a pleasant room with comfortable, modern furniture. The mothers brought their younger children with them—sometimes as many as three or four—and babysitting services were provided. The preschool children were told that this was a special time "for the ladies." To create an atmosphere of informality, I served coffee or soft drinks to the mothers before the meetings.

In the first meeting I suggested that the mothers discuss whatever seemed most important to them at their sessions. For example, they might share ideas about child rearing, or comment on the preschool program. The unstructured format did not lend itself to continuity of ideas; a thread of continuity did emerge, however, in the emotional undercurrent of the meetings during the year.

This was the first time these black mothers and a white teacher had voluntarily spent any length of time listening to one another. I knew that the mothers were accustomed to white figures of authority who did not listen. My training had been in the traditional leadership role that connotes initiative, action, and control. Therefore, the experience was unique for all of us.

I was interested in learning about the mothers themselves—how they thought, how they viewed life, how they raised their children. I perceived my role primarily as that of a listener, which differed significantly from the usual one at parent-teacher meetings in which a teacher talks and parents listen. Sometimes I asked open-ended questions: "Why do you think Susie likes to chase the boys?" or "What do you think she means when she hits them?" At other times I served as adviser and counselor: "You can get help from legal aid for that problem." "Why don't you talk with Mrs. Brown about that?" My role, which might be accurately described as nonintrusive, soon became crucial to the success of the mothers' group.

The mothers quickly came to view the meetings as theirs—a time when a significant adult would listen to them. During the year, I became increasingly aware of the great value that they placed on my presence as a listener. Several incidents illustrated this. Once when I planned to attend a conference, the mothers voted not to meet. Later in the year when I told the mothers I would not be with them the following week, they decided to meet without me if the tape recorder were used so that I could later hear what they talked about. The mothers seemed to be saying that my listening role was essential to the functioning of the group.

The importance of my listening was brought home to me whenever I became actively involved in their discussions: the mothers ignored my remarks and even interrupted my comments. In this way they unintentionally helped me focus on my stated goal—to learn about them.

The mothers also gained a sense of strength from membership in the group. They took the initiative in leading discussions; they explored common concerns; and they became enthusiastic as they found they could express themselves and share their ideas for mutual profit.

Each week the same process took place: mothers vied for position and leadership in the group. One mother, who dominated the group in early meetings, was told later by the other mothers that she "talked too much." Another mother did not say a word for

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ight sessions; then she brought pictures of her family to show everyone. After that session the women felt comfortable enough to use first names, including mine. Some mothers didn't talk a great deal, but when they did talk, the other mothers listened carefully. Leadership shifted during the year so that at one time or another each mother was able to give direction to the group.

When Dr. Hill and I reviewed the tapes of the meetings, we noticed that an increased noise level often signaled the introduction of a new idea or the reaction to it. If all mothers wanted to talk at once, the issue had touched a common chord. Unlike my experience with white middle-class groups in which people tend to restrain their emotions, I found that these mothers expressed their feelings openly and the mood of the group could be determined quickly.

During the first few sessions, the newness of the experience made me anxious, but as I listened, I learned to value the open, honest, emotional expression of feelings.

Varied topics

The discussions were free wheeling and informal. They ranged from the sharing of mutual concerns to the planning for social action. Each week the mothers' discussions varied in subject matter as well as in emotional content. For example, one week they talked about the kinds of "motherly love" that mothers can give to their children. The next week they explored some problems of racial prejudice. The following week they considered the general problems of maintaining a household.

The topics discussed during the school year could be divided roughly into three categories. During the first 4 months the mothers complained about the conditions that caused them to be frustrated—raising children in the inner city, disagreeing with their neighbors, being poor, being black in a white society, encountering housing authorities, taking their children to clinics, and fearing for the safety of their lives, the lives of the children, and their belongings. In these first months I felt the mothers' primary feelings were anger, loneliness, and a sense of helplessness.

During the fifth and sixth months the atmosphere of the meetings shifted, becoming more supportive. The mothers, while still complaining of their frustrations, began to describe their own methods of dealing with problems. They spent some time comparing good buys on food and home appliances, making suggestions for trustworthy clinics or doctors, dealing with local housing authorities, and so forth. They tried to find solutions for each other's problems.

I sensed a growing feeling of trust within the group, as well as the emergence of meaningful friendships. The mothers talked of visiting one another on weekends, going to movies together, taking turns babysitting, and having lunch together after our meetings. This seemed a particularly noteworthy development for these mothers, who had previously avoided new friendships, although they had been seeing each other daily while bringing their children to the preschool.

The mothers acknowledged that families in a huge public housing project tend to distrust one another, thereby forfeiting the natural bond they might find through friendship. Their explanation made good sense to me: hostilities are bound to arise when too many families live close together in a place where they must share one common laundry room, one garbage disposal, insufficient elevators or dark stairways, and where they frequently find their mailboxes open or broken. There are 16,053 people living in the housing development, 143 families for each 14-story building, and an average of six children per family. The mothers had compromised their personal needs by limiting their close friendships within the housing project to one or two trustworthy people. They were taking a chance, they said, when they enlarged their circle of friends.

A change in focus

At the beginning of the seventh month, a definite change occurred within the discussion group. Several mothers showed their interest in solving problems that affected the world outside their immediate families. For example, one mother urged the others to attend a PTA meeting at the local public school; another mother said that she had been attending meetings of the building club concerned with day-today problems of tenants in the housing development. The group decided to invite a mother who was involved in community action programs to speak at a later meeting. One mother said, "If anything is going to be done in our community, we've got to do it."

The change in the group's focus began at a crucial period in this country's history. Just after President Johnson announced that he would not run for reelection, the mothers developed an interest in national affairs. This was soon displaced in favor of more immediate concerns. Then the assassination of Martin Luther King, Jr., touched off serious rioting and fires in the business district only a block from the mothers' homes. There is no question that the events of April 1968 began a new era on Chicago's west side. This reconfirmed the mothers' decision to work for change in the community and in society.

During the last few months of the school year, the mothers agreed that "things are bad," and asked themselves what they could do. They said they were ready to take some responsibility for changing society. They began meeting outside the center, sometimes without me, and continued meeting periodically throughout the summer and the following school year. They became involved in activities to improve their own lives, the lives of their children, and those of other children as well. They attended school meetings, where they questioned teachers and administrators. Some took part-time jobs in community agencies, and others helped found groups dealing with specific problems. Several appeared on a panel discussion at a teachers' seminar to express their views on parent-teacher collaboration.

Personal concerns

The experience of the mothers in the group was different from what I had expected. I had thought the central focus would be the 4-year-old children who provided a natural bridge between us. However, the mothers did not raise questions about their children during the first seven meetings. In fact, they only discussed their children in four of the 25 sessions. At one point I tried to focus the discussion on the children, but this effort only inhibited the mothers in expressing their ideas.

When I asked the mothers what they wanted for their children, they became passive and waited to be called on. I decided to drop this type of questioning. Later without any prodding, the mothers spontaneously began to describe their goals for their children and to ask questions about aspects of child rearing. However, the mothers spent most of their time discussing the things that concerned them personally—where to shop, how to deal with their neighbors, whether attitudes toward black people were changing, and what to do about the numerous frightening experiences occurring around them such as rape, robbery, accidents, illness, and death.

The strength that these mothers gathered from the group enabled them by the end of the year to organize clubs within the various buildings of the housing project, to go to the housing management with their complaints, and to take a more active part in the local PTA. For the mothers, the group provided a community of concern, a place where they could express their feelings and frustrations knowing that they would gain the acceptance, assistance, and affection of other adults.

For me, the experience was an enriching one that helped me in understanding and becoming more sensitive to other people. It also gave me invaluable information about mothering, child-rearing practices, and parents' attitudes toward school and society that will be useful in my future relations with other parents. Moreover, it increased my understanding of the backgrounds of the children in the classroom, and so enabled me to plan with greater relevance to them.

The gap that often occurs between "what mother wants" and "what teacher wants" for the child became narrower because we had these sessions. I frequently found myself acting in collaboration with these mothers. The children became aware of this developing relationship, and they seemed to expect that their mothers and I would deal with school matters together. Indeed, they were right! When they felt they had done something wrong, the children would ask, "Are you going to tell my mommy?" They were less successful in playing parents and teachers against one another. Frequently during the year a mother would phone me to confirm something her child had said about school: "Did you tell Sam to bring his new truck to school, or is he making that up?"

Everyone involved directly or indirectly seemed to benefit from this program. After the mothers expressed themselves to others who were willing to listen, they exhibited more patience with their own children, seemed to listen more carefully to them, and seemed to be more receptive to their needs than before. I also got the impression that the mothers listened better to their husbands, although, of course, I cannot substantiate this with anything but a few clues. For example, toward the end of the year, one mother commented, "Men have feelings, too, I guess." The others nodded in agreement.

Within the group, all the mothers seemed to have increased their sensitivity to one another. The mothers also became more sensitive to the job that I, as a teacher, was trying to do with their children in the preschool. When they came to get their children, they began asking, "How did it go today?" Since I felt I could be honest with the mothers, I told them exactly how the day had gone—even when it had not gone too well. Sometimes a mother would say, "I don't know how you can stand it with all these children all by yourself every day!"

In my previous experience at the nursery school the communication between teachers and parents had been seriously lacking. The parent-teacher collaboration made teaching more exciting, more enjoyable, and much more effective. As rapport developed between the mothers and myself, I was able to discuss with them my ideas of the kind of activities that might catch the children's interest in the center. I also felt freer to ask a mother something I needed to know about her child. When a mother and I were able to listen to each other, we could "tune in better to the needs of the child." Even the children seemed impressed with the parent-teacher collaboration. They would announce proudly to one another, "My mother talked to my teacher," or "My mother came for a meeting."

Parent involvement

The original plan called for one mother to work in the classroom every day to help me as well as to stimulate discussion among the mothers. This part of the plan never really succeeded. But the mothers' interest in what went on in the school did grow. By spring the mothers were selecting their own times to visit the classes. On several occasions when I had to be away from the classroom, the mothers took turns teaching. Whenever the mothers took total responsibility for a class, the project paid them for their services.

The children were proud to have their mothers become part of the teaching staff, although occasionally this puzzled them. One child, for example, asked, "If my mother is my teacher, then will you be my mother?" The children also commented on the various teaching styles of the mothers, as they had commented on my style. ("Mama, my teacher's white, but she's a lady just like you.") They recognized the special talents that the different mothers brought to the classroom. For example, they obviously knew that one mother had a good sense of humor and another was especially good at telling stories. Their observations of the mothers' different teaching styles stimulated the children's interest in their own and others' special skills. For example, one child would recognize another as someone who is good at building with blocks, someone who does puzzles well, or some one who makes good pictures. The children began to ask each other for help in developing these special skills.

Mothers who visited the class regularly observed the methods I used to foster learning and psychological growth. I would make clear to them my concern for the individual development of each child. On one occasion, for example, when a mother called the smallest boy in the class "a baby," I explained to her that I wanted the boy to see himself not as a baby, but as a 4-year-old with the same abilities as his larger classmates. After I enlisted this mother's help, she did a great deal to help the other children treat the boy as an equal. She began saying to the children, as I often had, "He can do it for himself. He's 4 years old, too." Later she commented to the other mothers about how much the child had progressed.

When the mothers visited the classroom for the first time, I used their comments about the children to open the way for our dialogue regarding children's behavior, what the children were learning in play, and how the activities could help them grow. The mothers picked up the ideas quickly and began looking for growth and change in the children and for meaning in the children's activities.

At the same time I learned to use the words and phrases that the mothers normally used when talking to children. This allowed me to converse with the children more easily. For example, when a mother said her child was "messin' around," she meant that he was disrupting the household, getting into things that didn't belong to him, and also that he was curious about his surroundings. Without abandoning good English, I tried to make the children comfortable by adopting some of the idioms familiar to them: "Don't mess with that!" "You're messin' around with Jimmy's things," and "Let's mess around with this fingerpaint."

One of the most productive discussions of children's behavior occurred after two mothers had worked in the classroom for a week while I was at a conference. The other members of the group regarded these mothers as strong personalities, and had chosen them to work with the children. Both mothers expressed strong opinions about their experience. One mother told the group she liked being with the children: "They didn't act as bad as you might think." She said she felt they were learning a lot.

The other mother said that she too enjoyed the teaching, but that she thought I was too permissive and let children get away with too much. She said disapprovingly that the children used "nasty" words, had no manners, and played in water; she told about one child's hitting another. Her report sparked a lively discussion.

The mothers expressed concern about how children were disciplined and what controls were kept on children in the preschool, making it clear that they wanted their children to be "perfect." They asked me to explain what I was trying to do with the children, and what I expected to happen in the course of the year. They also questioned me about why children behave as they do, how children make adults feel, how the life they knew as children differed from life as it is for their children, and how the preschool staff handles various situations with children.

I explained some of the program goals and the relation of these to the mothers' complaints. The mothers listened attentively to my explanations about nasty words, manners, water play, and hitting. I had been permissive about the use of nasty words, I said, because I felt all 4-year-old children like to show their knowledge of nasty words. I agreed that the mothers had a legitimate complaint in this regard, and since this was an important issue for them, I promised to curtail the use of such words in the classroom. Some discussion ensued about how children learned these words in the first place. The mothers agreed that the children often heard them from their parents, but they still felt that the children's use of them should not be condoned. We also discussed each of the other issues that had arisen and reached agreement as to how they might be handled in the classroom.

This was a difficult session for me, but it opened the way for the collaborative approach that we followed for the remainder of the year. After this session, when these mothers had questions about the preschool program, they came to me; I explained my reasoning and listened as they expressed their points of view. Frequently in an individual conference a mother and I would discuss our differences in approach and goals. Through these joint efforts to learn what each of us wanted for the child's healthy growth, we were able to reach compromises that did not compromise good educational practices. Such experiences helped me sort out the essential from the nonessential in my teaching efforts.

Certainly, questions can be raised about the success of this demonstration in parent involvement at the Martin Luther King Center with mothers of high-functioning 4-year-olds. The demonstration was not scientific in the sense of collecting data to measure the effectiveness of the method used to establish understanding. Only the feelings and intuitions of those who were involved have been recorded.

Some questions

The questions remain:

"Did the children whose mothers participated in the discussion group in fact have a more productive year than they otherwise would have had?"

"Will the mothers who participated continue to take an active part in working with their children's teachers as the children progress in school?"

"Can teachers benefit from the intimate knowledge that a mother-teacher discussion group relationship affords?"

"Is the time spent in group meetings really worthwhile?"

While there are no positive answers, these questions must be considered in the light of current trends toward more community involvement in school programs. How these trends will ultimately affect learning is difficult to evaluate. But is there any other realistic course than to try new techniques in a situation that has been so poorly explored in the past?

Such questions need to be faced with an awareness that public education must change if teachers in preschools as well as those in elementary and secondary schools are to reach and teach all children in our society. Can schools and their teachers afford to remain isolated from their school communities or from the parents whose children they teach? There is a great need for teachers to risk the discomfort of new roles, in which criticism and compromise are inevitable. Persons in related service professions—social work, psychiatry, psychology—can help teachers develop the skill, confidence, and self-awareness to become educators in society rather than teachers of a few hundred children. Such role expansion can provide a powerful avenue to improve education for children and to facilitate personal growth for parents and teachers.

HELPING HOUSEPARENTS FIND AND USE THEIR CREATIVITY

HARRY E. GROB, JR.
ERIC E. VANDOREN

"Study time!" yelled the housefather to the teenage delinquent boys sitting in the cottage dayroom. Protesting mildly, the boys dragged up the stairs to their rooms. The housefather switched the television set to a cartoon program, sat back in his easy chair, and commented sadly to his visitor: "'Course the boys won't really get down to studying. Me—I had to quit school to work and I ain't ever been much."

According to correctional theory, this well-intentioned houseparent was supposed to be offering institutionalized boys an encouraging, creative life experience. He was an intelligent, honest person who had more or less drifted into correctional work. His qualifications included a certificate from an inservice training program, frequent reminders that houseparents were the "spokes of the institutional wheel," and an ability to get along with the other staff members, who called him "Pops." Although he had spent all his adult life in correctional work attempting to help young people, he had never been included in the planning and evaluation of the programs in which he worked. No wonder he felt worthless.

How differently he might have felt and how much more might he have helped the boys in his charge had he been encouraged to contribute his own ideas to the institution's program. This failure to encourage creative thinking from the persons in closest contact with the delinquents in care is a paradox in the correctional field.

When we, the writers of this article, assumed responsibility for the treatment program at the Chaddock Boys School, a private institution for juvenile delinquents in Quincy, Ill., we remembered this housefather and scores like him whom we had known in the past. We decided to find out what a small institution with a social work orientation could do to help houseparents become creative in their work and aware of their own value and creativity.

Our goal was to stimulate houseparents to express their real opinions of the treatment program and so enable them to put their worthwhile ideas into action.

We hoped they would also learn to face the problems of helping delinquents change, free themselves of immature in-fighting with other houseparents, distinguish between superficially "good" institutional practices and realistic, creative helpfulness, and realize dynamic fulfillment and relate it toward helping youngsters.

For 3½ years we offered all staff members at Chaddock—maintenance and professional staff as well as the houseparents—an opportunity to seek this goal with us. We will here, however, confine our observations to the houseparents' response. We regarded staff members' participation in making decisions as elementary correctional group work. We realized, however, that houseparents who have always been told what to do will initially misuse opportunities to help devise a treatment program. They must first test the authorities to learn if they are to be listened to and treated with respect. In time, the houseparents recognize and use such opportunities properly and the youngsters in care begin to profit.

Busting loose

A list of rules, prepared and published by the administration, regulated cottage routine at Chaddock. Although houseparents said they complied fully, they often ignored the official rules because they resented having had no part in making the decisions. In practice they made their own rules and then quarreled about "different rules in each cottage."

We proposed that the houseparents meet with us each week to work out broad principles for a manual on cottage routine. More specific rules could be worked out by houseparents and boys in each cottage. At the meetings, each staff member would be equal—no one would "pull rank"—and each participant would rotate as discussion leader. All houseparents agreed to take part.

During the first months of our meetings, the houseparents did everything possible to defeat themselves. The discussion group was a new—and thus frightening—experience for them. Most of them, for example, acted like tyrants, especially when they were discussion leaders. Each leader attempted to bulldoze his own ideas through the group and discouraged discussion by the others. The leaders' comments indicated that they were also behaving like tyrants in the cottages—allowing practically no participation by boys in establishing cottage rules.

Some houseparents responded by testing the one acting as discussion leader. They would fall asleep in the meeting, whisper, tell jokes, stage tantrums, and "mob the leader"—"some of us got together last night and here are the rules we want."

The houseparents also tested us. Several times we let ourselves be baited into counterattacks. Our defensiveness took the form of silly lectures on being "fair" or "democratic." More often, with emotions under control, we pointed out that "all of us are trying to use our potential to be creative" and "all of us are trying to help the boys."

After the list of rules was completed, the houseparents decided to review them in a continuing series of meetings. Some houseparents said a review was needed because they had "pushed the rules way out" to test us. Others said that "rules ought to be changed to fit the particular times"—a belief we regarded as a move away from stagnation.

During the review, the houseparents showed a marked change in behavior. The leaders encouraged discussion without forcing their own ideas upon others. A more businesslike attitude prevailed, and many practical ideas were suggested. We told the houseparents that they had learned to be better discussion leaders than we were.

Toward the end of the review a housemother said, "When we started these meetings, part of the idea was to offer the boys the same experience that we are having in determining some of our own rules. I'm scared the boys will take advantage of this freedom."

Other houseparents expressed a similar fear, until a housefather changed the mood of the meeting by saying, "At first I took advantage of this kind of meeting myself but then I grew up. I think I can help the boys do the same."

To demonstrate his point, we conducted a number of group discussions with the boys, inviting the houseparents to attend as observers. These meetings encouraged the houseparents to support our efforts.[1, 2]

All the houseparents then began to meet with the boys in their cottages "as equals" to work out rules, using the rotating discussion-leader system. They were eager to talk to us about their experiences in these meetings. They told us how shocked they were to see many of their former patterns of behavior reflected in the behavior patterns of the boys. One housefather observed, "Bill bulls just like I used to do if the others don't agree with him." They were also impressed with the creative ideas that the youngsters expressed. A housemother remarked, "When you start being a human being with kids, you never want to go back to anything else."

Contributing to the paradox in institutional care are unspoken doubts about whether, in spite of honest efforts, anyone can *really* help delinquent youngsters change. Houseparents and professional persons alike seem susceptible to a kind of hopelessness. They may give lip service to the theory that delinquents can change but fail to act as if they really believe it. Those staff members who feel thwarted about being able to change constructively themselves tend to transfer negative feelings to the boys in their care.

Therefore, the houseparents in our group discussions were openly encouraged to talk of their feelings of wanting to give up—"give-up-itis," we called it. They told us, "A person really wants to help these boys. You try to give them everything you've got. But most of the time, there's no change, not really. Sure, to get along with people and to keep your job, you say otherwise. Down deep, though, you give up after a while; you feel lonely just like these kids."

We suggested that together we "bust through your fatalism." The houseparents agreed to set up small committees to study the problems that depressed them. These committees operated without any interference from the institutional power structure.

Committee 1, for example, attacked the question, "How do we know a boy has really improved?" Its first report consisted of stereotyped answers. The staff rejected the report and asked the committee to look further into the question. The committee members channeled their angry feelings into action. They interviewed professional people in the local community—physicians, court officials, teachers, social workers, and others. They also asked blunt questions, through correspondence, of national experts in the fields of corrections and behavioral science.

The determination of committee 1 stimulated all of us to develop a positive, aggressive attitude in evaluating a boy's progress. Team meetings became opportunities to express doubts freely. The members of the staff complimented each other for objective, constructive statements regarding a boy's situation. However, a judgment of "no hope for this boy" always brought the question, "How do we know?"

At the end of the year, committee 1 made some observations—but gave no answers. In a final report, the chairman, a housefather, made these following points:

1. All of us have gotten a start in trying to figure how to judge a boy's progress.

2. We have learned that you have to study a boy when he comes here, stay close to him, talk over your concerns with him. You have to be able to talk to your coworkers about this boy without fighting and fussing.

3. The biggest thing we learned is about us. If you think you can change for the good, you'll think that most boys can too.

4. Look at yourself first, then look at the boys.

These committee assignments showed that, given the opportunity to be creative, houseparents can aggressively face the problem of bringing about constructive change—both in themselves and in delinquents.[3]

The houseparent-versus-professional-staff conflict is a senseless cancer that consumes creative energies in many institutions. Houseparents at Chaddock were spending too much energy in expressing hate for the professional staff members. In turn, the professional workers often displayed contempt for the houseparents. The houseparents were equipped with heavy artillery to do battle—they were acutely aware of the professional workers' shortcomings.

The boys were cognizant of the houseparents' feelings and had developed skill in further inflaming the situation. For example, when one of the writers of this article made his first visit to the institution, he introduced himself to a boy and asked for directions to the front office. The boy gave the information and walked toward a cottage where he was met by a housefather.

"Who's that?" the houseparent asked. The boy identified the visitor.

"Was he rough on you?" the houseparent demanded.

"Well, I guess not," said the boy.

The housefather exploded: "You act like he mistreated you. I bet he did. Those damn social workers!"

Dealing with conflict

Institutional administrators can support constructive efforts if they want to or they can encourage conflict by playing staff members against each other.[4] We therefore discussed the existence of such conflict with the institution's administrator, indicating our strategy for dealing with it. During the entire project, we were willing to discuss the remotest reference to staff conflict with anyone bringing it up. Our constant theme: Let people use their potentiality for creative activities so the boys can do the same.

From our past experiences as hospital ward attendants, houseparents, and professional correctional workers, we had learned that such conflict could be resolved through bold—even dramatic—thrusts by staff members working together as human beings. Furthermore, it would stay resolved unless an administrator or someone else stirred up emotions. We were forced to use our own imaginations in devising ways to solve the conflict, however, because the correctional field lacks literature giving practical advice on houseparent-professional staff problems.

At one of our first meetings with the houseparents, we appeared in casual clothing like that worn by the housefathers. Intentionally we began a rambling, theoretical discourse on program goals. This elicited a furious verbal attack from the houseparents. We asked questions to encourage further expressions of opinion. Next we read excerpts from an article published in a professional journal relating to the solution of staff conflict. The houseparents grinned, giggled, and then laughed out loud. We joined in. Then we ended the meeting abruptly, saying above the laughter, "Let's talk some more later." This was also our answer to individual houseparents who asked why we laughed with them at "that college writing."

It was customary for housefathers to perform maintenance chores in the mornings while boys were in school. The next day after the meeting, we went out early to help with the cutting up of tree trunks. Intentionally we pushed ahead of the houseparents to do the dirtiest, hardest part of the work. We continued this pattern for more than a month.

During this time, we consulted in our office with individual houseparents about "boy problems" in a friendly, warm manner. We said nothing when they commented about our physicial labor. Housemothers began to tease their husbands, "Those fellows may be white-collar workers, but they sure can bust a log." Housefathers began coming to us individually, asking, "Can we talk about the trouble?," thus referring obliquely to the hostility they had exhibited to us as professional workers.

Nonchalantly we said, "Everybody can keep his job here, as long as he wants it, whether he hates us or not. Do we really talk or just patch up?"

The hostility of the houseparents toward us as professional staff members began to vanish when they realized that they could discuss openly with us anything they wished, when they discovered that we treated them as competent human beings, and when they involved themselves in constructive activities.[5] We continued to participate with the housefathers in physical work, explaining, "We all help in all parts of the program." Occasionally when under stress, individual houseparents regressed to displays of hostility. Then we said bluntly: "You can start using that old crutch or else face the problem like adults."

Hopes and dreams

After several months of group meetings, we reviewed staff development at Chaddock. Although we liked to think that we were helping the houseparents develop ways of releasing their creativity, deep down we knew that only a small impact had been made. We decided to review each houseparent's situation at the end of each day and offer suggestions for making better use of the houseparents' potential. These reviews were similar to the ones we had been conducting for the boys.[1]

When we told the houseparents of our plans, many of them envisioned a minute, fault-finding examination. They quickly recognized, however, that the reviews were more positive. Eventually the houseparents themselves began holding daily reviews with their colleagues, and later with the boys.

Our daily reviews disclosed many personal hopes and dreams of which we had been unaware. For example:

One housemother was threatening our confidence in ourselves. She was intelligent, honest, dedicated. We found her inquisitiveness, her eagerness to explain things, and her criticism of the program troublesome. Through conversation with her we learned that she had always wanted to be a teacher. At 63 years of age, she saw no hope of fulfilling her longing. Therefore we asked her to talk to the entire staff on the housemother's role in the treatment of delinquents. Later she taught a regular course in this subject for the staff and served as key instructor for new houseparents. She was also selected to work out procedures for encouraging the boys to greater achievement in school, procedures that were subsequently accepted by the staff. With little direction, she successfully applied her creativity to these tasks.

One housefather never seemed satisfied. His gripes about the program irritated us. In conversation, he told us of his dream to develop a new approach to the treatment of delinquent boys. At 50 years of age, with only an eighth-grade diploma, he was not interested in getting the necessary education to prepare for a program director's job. Yet he had the intelligence and skill to contribute materially to the institution's program. We encouraged him to mention his ideas for improvements, and these were accepted by the staff. For example, he formulated a new intake procedure for the institution.

Another housefather sent in a particularly well-written report. Our inquiries revealed that he dreamed of writing a book about institutions. We first encouraged him to write an article for a professional journal. After the article was published, we asked him to read some of the manuscript for his book in a staff meeting; the response was enthusiastic. Later while he was working in another institution, his book was published.

Creative environment

A creative environment in an institution for delinquents *could* be described in terms of well-meaning staff members racing about "doing good for others," inhibiting normal responses "for the cause of corrections," and, in the confusion, allowing the delinquent children to manipulate them. Social workers have often been charged with promoting just this type of chaos.

However, we found that when given opportunity to be creative, our houseparents began to give thoughtful consideration to their actions. They also expressed their real feelings more freely than they had previously. And they were much less susceptible to manipulation by the boys. Flattery, attempts to incite staff member against staff member, and statements designed to arouse feelings of guilt had little effect upon houseparents who felt secure.

Boys, who knew they were accepted and believed in by the staff, did not need to deceive themselves with phony measures of progress.[6] They were relieved of the need to fool either themselves or the houseparents when they saw that the houseparents no longer needed to allay feelings of failure by pretending to see progress where none had been made.

Although Chaddock was a small institution, we feel that the principles we have described here can be applied in larger institutions. Larger institutions, however, may contain more roadblocks to creative expression. Their staffs may include uninterested persons, hired just to keep the positions filled. "Lost staff members mean lost youngsters," is the rationalization. But this "numbers game" breeds a sense of hopelessness in houseparents that they inevitably pass on to the youngsters.

We feel, however, that such road blocks can be dealt with by using approaches similar to those we used at Chaddock: the formation of creative problem-solving committees; the holding of section or department meetings built around staff ideas; the use, wherever possible, of ideas presented by staff members; and a sincere search for individual interests and talents that can be applied imaginatively in their work.

For example, one trend in large correctional facilities is to split the staff into small working groups,[7] called teams, blocks, units, or something similar. Working with segments of the institutional population, these groups function rather independently. This mode of operation provides staff members with support from each other and an opportunity to share information and ideas.

Reexamination

When the creativity of the houseparents at Chaddock reached a high peak, we asked, "Is this whole business—the program, staff democracy, a belief in troubled kids—a fraud?"

Several houseparents replied in the following vein: "At first we thought that you guys were trying to fool us, but not now."

"How can you be sure?" we asked. When the houseparents attempted to answer the question, we picked their answers apart. This puzzled them.

Harry E. Grob, Jr. (left), and Eric E. VanDoren report here on their experience with houseparents while working as program director and social worker, respectively, at the Chaddock Boys School in Quincy, Ill., a training school for juvenile delinquents. Both authors are now on the staff of the Illinois State Training School for Girls, Geneva, Ill., Mr. Grob as chief of social services and Mr. VanDoren as director of the Reception and Diagnostic Center for Girls.

We explained that sometimes an administrator offers houseparents a taste of creative opportunities and—unknown to them—purposely misuses whatever they achieve. We pointed out, as an example, that our group members were busy giving of themselves in helping boys, they trusted each other, and they were happy. It would be simple to deceive them by taking inappropriate advantage of their feelings of trust.

In a series of informal meetings to review the history of correctional institutions and the development of treatment programs, we emphasized the tendency of institutional staff members to follow fads. We showed how each major procedure at the institution might be rigged to appear helpful.

It took time for the houseparents to digest these elements of reality. At first they seemed to feel overwhelmed. Next came self-examination.

"I can see how a person just can't sit," a housemother remarked. "If you want a creative situation, you have to work for it, to think and speak up."

"There's another angle," a housefather said. "I saw myself in a lot of the things you guys said. Made me wonder how often I try to fool the boys, just for show."

Gradually, the houseparents became more aggressive in evaluating program procedures. They would not be rushed into making decisions; they became adept at asking, "How will this really help the boys?" For example:

> The houseparents decided that all the boys should attend both Sunday school and church services in the community each Sunday because "those boys need to go to church and to be made to listen and get something out of it." They ignored the fact that most of the boys had never attended any church in their lives.
>
> After a while, the houseparents began listening to the boys.

The boys said they disliked attending the church service because people stared at them and they were unable to follow the "boring" sermon. However, they did not mind attending Sunday school where they could participate in discussions with other teenagers, including girls. When several ministers supported this position, the houseparents agreed to change their rules.

Some mistakes

We made many mistakes in working with houseparents. Most of them were due to poor evaluation of creative expression.

Often we expected too much to be accomplished too fast. For example, we expected the houseparents to transfer their own creative experiences to the boys more quickly. Our frequent expressions of disappointment retarded the growth of some houseparents. We had to remind ourselves constantly that people who have been thwarted most of their lives cannot become creative overnight or immediately convey new attitudes to others.[8]

We sometimes substituted our own goals for those of the houseparents. Too often the hopes and dreams we remembered from our own days in subservient institutional positions crept through unconsciously. We wanted houseparents to have advantages that we had not enjoyed whether or not they were ready.

Our idea of having a staff library is an example. The houseparents responded positively to the idea and formed a library committee. We contributed money to the remodeling of a room and donated some of our own books. Then we noticed that most of the houseparents who used the library were only forcing themselves to do so. This attitude annoyed us until we realized that they were not really ready for a library and had only agreed to set it up out of kindness. Said a housefather: "I guess we figured you guys had a right to see some of your ideas in action; you've been fair with us."

A third mistake was in not recognizing that we could not help some houseparents through the group program. We were unsuccessful in keeping those houseparents in the group: (1) who preferred to be told exactly what to do instead of figuring out solutions to problems cooperatively, (2) who wanted us to check their performance by making surprise visits to the cottages, and (3) who enjoyed conflict for its own sake. Although we did not find ways to release the creative talents of such houseparents, we still believe it is possible to do so.

Another mistake we made was in not being consistent in responding to the houseparents' creative suggestions. We had invited the houseparents to speak freely and planned to react constructively to their ideas. But at times because of fatigue, personal worries, or discouragement, we unintentionally conveyed a sense of indifference by implying, "Don't bother us," and even, "Aren't you getting out of line?" We should at least have given an explanation such as, "You know I want your ideas. But this has been a bad day for me, so let's talk it over later. In the meantime, call me 'Old Grouch.' "

Even more regrettable, we occasionally questioned the motives behind a houseparent's suggestion. This error resulted in the loss from our program of several well-meaning but misunderstood houseparents. They had trusted our encouragement to be creative, but their ideas had frightened us, and we had rejected them.

Another mistake we made was to give in to the idea that uncreative adults can never help troubled youngsters. Houseparents tend to treat the young people in their charge in the way that they, themselves, are treated.

The Golden Rule might be paraphrased for administrative and professional staff in this way: "Do unto houseparents as you would have them do unto the kids."

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ONE PARENT ADOPTIONS

ETHEL BRANHAM

One of the axioms of our child-centered society is that every child needs a permanent home of his own. Yet some children are threatened with having to spend their childhood shifting from one temporary foster home to another because no permanent home can be found for them. Faced with a rising number of "hard-to-place" children, child-placing agencies have in recent years been expanding their resources for providing children with permanent homes, to include, among other couples, those who will provide long-term foster care, subsidized adoption, guardianship,[1] and adoption across racial lines.[2]

Another resource, less frequently tapped because it was long considered "outside the pale" of social agency policy, is the adult who has no marital partner but wishes to adopt a child. Only a few agencies have turned to this resource on the theory that a permanent home with but one parent, if carefully selected, can provide a homeless child with the security and love he needs. One of these is the Los Angeles County Department of Adoptions.

When the County of Los Angeles Department of Adoptions (then called the Bureau of Adoptions) was established in June 1949, it was charged with the special responsibility of finding adoptive homes for children who are difficult to place—children of minority racial groups or of mixed racial parentage and children with severe medical problems. The agency services were also offered to all mothers or expectant mothers who were considering relinquishing a child for adoption.

At that time in Los Angeles County, independent and black-market adoptions were prevalent, and the need for another adoption agency was plainly evident. Families wishing to adopt healthy babies of Caucasian background through licensed agencies usually waited several years before they received a child. Since the various adoption agencies had, on the average, about 10 suitable homes for each healthy white child, the rejection and dropout rates among applicants for children were high. Nevertheless, the child with special needs was usually overlooked. With so many prospective adoptive parents available, the new agency was optimistic about its ability to find homes for these overlooked children.

The intervening years have brought significant changes in the adoption picture. More healthy Caucasian babies are available for adoption, the waiting period between application and placement is shorter, and the qualifications for adoptive parenthood set by the agencies are related more to the applicant's ability to nurture an adopted child than to the scarcity of children. None of these changes has solved the difficulty of finding homes for children with special needs. Therefore the Department has supplanted its spotty and spasmodic recruitment efforts with an aggressive, full-time publicity program. It has also reconsidered a longtime policy of automatically rejecting lone adults as potential adoptive parents. Late in 1965, it began placing selected children for whom no other homes could be found with persons who had no marital partner in their home.

This practice became possible because that year the California State Department of Social Welfare revised its adoption regulations to allow acceptance of single persons as adoptive parents. The new policy clearly reiterated the established principle of adoption practice that *a two-parent family is the best of all possible choices for an adoptable child*, but it recognized the fact that two-parent families could not be found for all children needing the security of a permanent home.

In late 1965 the Los Angeles Department of Adoptions had registered with it more than 300 children available for adoption for whom adoptive couples were not readily available. This group included about 275 healthy Negro and part-Negro children of various ages,[3] 60 Mexican-American babies, 18 children of mixed racial background other than part

Negro, and several Caucasian, Negro, and Mexican-American children who had severe medical problems. When intensive efforts to find two-parent adoptive homes for these children failed, the Department decided to look into the possibility of finding them one-parent families.

The Department made its first one-parent placement in December 1965. At about the same time it launched a publicity campaign to make known its needs for adoptive parents, whether single or married, the first time any such campaign had invited single persons to apply. In the following 3 months it received 1,813 applications for children, the largest number in a comparable period since 1949. Most of the applicants were couples, but even so, the Department did not have enough suitable two-parent homes for all children with special needs. During the 2 years 1966 and 1967, the Department placed 40 children for adoption in homes with only one parent—approximately one-half of 1 percent of all the children placed by the Department for adoption during that period. They were placed with single women, divorcees, widows, and even a single man.

To learn what kind of parents these children acquired, the agency in 1969 reviewed the records of 36 of these 40 placements. Of the four children whose cases were eliminated from the review, two had been placed as the second adopted children of lone women; one, a school-age child, had been returned to the agency by the prospective adoptive parent; and one, an infant, had been removed from a questionable placement.

Parents' characteristics

In the 36 one-parent placements, 35 of the adoptive parents were women, 21 of whom were Negro; 10 were what is known in the Southwest as Anglo—Caucasian of non-Mexican background; and five were Mexican-American. The one man was a Negro.

These parents ranged in age at the time of placement from 30 to 54. Their educational backgrounds ranged from incomplete high school to achievement of postgraduate degrees. Half had at least some college work.

The review showed that the kinds of people likely to become lone adoptive parents are limited by self-selection as well as by the agency's selection standards. They seem to share many of the characteristics and life-styles of couples who adopt across racial lines. Marmor has described the latter as "people with a relatively high level of emotional maturity, high capacity for frustration tolerance, and an ability to pursue a relatively independent course in life, without being overly influenced about what other people think." [4]

These qualities stand out clearly in the descriptions in the agency records of the lone parents who have taken children for adoption. Moreover, the very fact that women with no husbands to give them financial and moral support are willing to form a family indicates that they are not greatly influenced by what other people might think. Their willingness to tackle the job of raising a child without the support of a husband suggests that they have a high degree of frustration tolerance. The adoption workers have described them as both self-aware and self-confident—strong enough to accept the likelihood of encounters with those who would imply that the adopted child was a child born out of wedlock and secure enough to handle the innuendo. For the most part they were well-organized systematic managers. They exhibited good intelligence, although some did not have a good education. They tended to be employed in jobs that gave them opportunities to deal with people rather than with things. Their lives included self-enhancing interests, hobbies, travel, and church or community involvement. Their motive for adoption was what they could do for a child rather than what the child could do for them.

"Vigor," "stamina," "patience," "understanding," "sensitivity," "sense of humor," "relaxed," "levelheaded" appeared frequently in the records in describing these parents. For the most part, they seemed to have full lives, enjoyable occupations, and something to give a child.

The children

The children placed with these parents ranged in age at the time of placement from 3 months to 5 years.

Six children of mixed racial background—five Anglo-Negro, one Mexican-American-Negro—and 15 Negro children were placed with Negroes. These children ranged in age from 3 months to 5 years, but the majority, 15, were under 2 years of age. They included more than twice as many girls as boys, although both sexes were about equally represented among all the Negro children available for adoption. The preponderance of girls placed with lone Negro women reflected the women's requests.

Four of the children placed with Anglo women were of mixed racial background; three of them had one Negro parent and one Anglo parent, and one had one East Indian parent and one Anglo parent. Of the six other children placed with Anglo women, two were Mexican-Americans for whom no other homes could be found, three had serious medical problems, and one had emotional problems. Eight of these children were less than 1 year old and the other two were under 4 years of age.

Of the five children placed with Mexican-American women, three were Mexican-American in heritage. The two others were placed with Mexican-American women because of their religion: both were born of Catholic mothers—one was a part-Negro child and the other, an Anglo child with bilateral club feet. The Mexican-American homes were chosen for the latter two children because they offered a Catholic upbringing. Three of the children placed with Mexican-Americans were less than a year old and the other two were under 2 years.

Most of the Mexican-American children placed with single parents were boys; two-parent homes are easier to find for Mexican-American girls, who are frequently accepted by Anglo couples.

Male companionship

The need for children, especially boys, to have a father figure to serve as a role model for sexual identification has been a major reason adoption agencies have avoided placing children in one-parent homes. But as Herzog and Sudia have observed, "children learn about maleness and femaleness from many sources, including adults in their homes, their peer group, TV, movies, and other mass media, and especially the persons—children or adults—who influence them particularly." [5]

The records show that the workers have paid special heed to the availability of male companionship for both the adoptive mother and the adopted child. Most of the 35 lone women with whom children were placed had close male relatives interested in the adopted child—fathers, brothers, sons, nephews, and, in a few instances, even former husbands. Thus the children had grandfathers, uncles, brothers, cousins, and adult male friends who could give them the kind of intimate contacts needed for male identification. Many of the women also had close male friends who took an interest in their plans for adoption and in the child after placement. In some instances the male friend had been interviewed during the adoption study and had been present when the child was first shown to the prospective adoptive mother.

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But even without male figures close to the family, children with an emotionally mature mother can be expected to develop an appropriate sexual identity. As Kadushin [6] has pointed out—

> . . . the child in a single parent home has many secondary sources of identification through which to learn male behavior. Sex is working on our side in this matter. The boy possesses the observable, palpable, physical properties and attributes of a male (and) society expects him to behave as a boy. His mother, assuming she is reasonably normal, responds to the boy as to a male, approves of and encourages appropriate masculine behavior.

Two-thirds of the women had been married. This prior experience plus a yearning for the opposite sex, evident in all of the mothers, suggests that these single parents could compensate effectively for not having a man in the home. Most of them dated regularly. Many had interests and hobbies involving group activities that included both sexes. Men, both in and outside their families, seemed interested and willing to become father surrogates.

This proved to be true in the case of Mrs. O, who had been divorced after a marriage of many years. A 5-year-old boy was placed with her.

> Mrs. O has three married children and six grandchildren. In spite of the divorce, her family is closely knit and all the members have welcomed the adopted child. Mrs. O has a large capacity for fun, patience, and understanding, and obviously enjoys children. A vigorous, self-assured person, she holds a professional civil service position and owns her own home. Although she was not interested in any man at the time of her divorce, she has since developed a close friendship with a man who is devoted to the child.

Placing a child for adoption with a mother who is over 50 is also a departure from traditional practice. The agency had already raised its age limitation for adoptive couples, first only with members of racial minorities and eventually across the board.

In approving homes of older single persons for adoption, the agency's workers were alert for elements that offered protection for the child's future as well as opportunities for normal development. This was so, for example, in choosing Mrs. D, a divorced Catholic woman, also in her early 50's, as an adoptive parent for a 7-month-old baby.

Mrs. D has a steady income and can well afford to support a child. Since she is no longer working she can give the baby full-time care. A 40-year-old man, a godchild of hers, has offered to sign any legal paper necessary to assume responsibility for the child in the event that something happens to Mrs. D. He lives across the street from her with his wife and five children.

In this case a family very close to the adoptive mother was readily available to take over if needed and also to provide the male models for helping the adopted child grow up to understand the difference in the social roles of the sexes.

Income and employment

The 36 lone adoptive parents had annual incomes ranging from $3,000 to $12,996 a year. All but six had yearly incomes of $5,000 or more and all but 13, incomes of $6,000 or more. Many, like Mrs. D and Mrs. O, owned their own homes. All but two were employed, and most of them had adequate health insurance and life insurance. A few had income from property or other investments. The two who were not employed had independent incomes and preferred to devote full time to the care of their children.

Two of the mothers had incomes as low as $3,000. Both, however, had good management ability, good prospects of improving their economic positions, and the emotional support and interest of close relatives or friends. One of these women, for example, was a young widow, Mrs. N, who was chosen to be the adoptive parent for a 5-month-old girl.

Mrs. N works on an assembly line from 4:30 p.m. to 1 a.m. These hours allow her to be with the child most of the day. Mrs. N's sister and her family live next door to her and take care of the child while Mrs. N is at work.

Mrs. N is the sixth child of a large, closely knit family. All but one of her brothers and sisters live in Los Angeles County, as do both her parents. She also has 18 nieces and nephews, 15 of them children and three adults. Before the adoption, Mrs. N was the only childless member of her sibling group. Cooperation is a well-ingrained characteristic of this family. Mrs. N's sister, from whom she rents, lowered Mrs. N's already low rent to help her support the child.

Mrs. N manages well. She owns a car, which is fully paid for—as is all her furniture. She carries adequate life insurance and enough health insurance to cover medical expenses for herself and her child. She has completed a course as a grocery checker, which she expects will help her obtain employment with a better salary. Moreover, she may eventually have the support of a husband, for she is a handsome, warm, cheerful woman who gets along well with men.

Placing children for adoption with women who are employed full time is another break with traditional adoption practice. But today the working mother is commonplace. The agency has therefore not regarded such employment as a sufficient reason for keeping a warm, emotionally stable woman from becoming a parent of a child desperately in need of a home of his own. It does, of course, look into the adoptive applicant's plan for providing child care while she is at work.

The records show that all the working adoptive parents took a leave of absence at the time they received the child, the majority for at least a month and only five for as little as a week. Nearly a third of these mothers had relatives or housekeepers living in their homes or next door who cared for the child in the mother's absence. The rest had arranged for child care in the homes of relatives, licensed day-care facilities, and nursery schools during their working hours. Three worked only part time and so could spend most of their time with their children.

Attitudes toward children

Almost without exception these lone adults had had rather deep relationships with children before ap-

The happiness on the face of this child reflects the security of a home of his own in an atmosphere of tender loving care. Such an atmosphere can be provided in an adoptive home, even when there is only one parent, some social agencies believe.

plying for a child to adopt—either through their own families or through their employment. Eight of the women had raised other children—born to them or adopted—before applying to the department for a child. The one man with whom a child was placed had previously had sole responsibility for 3 years for the support and care of two young nephews. One of very few male applicants for a child, he came to the agency after his nephews' mother had found herself in a position to take her children home with her.

Mr. R was the youngest of a large group of brothers and sisters, who had helped their mother keep the home together after their father deserted the family. He had matured into a relaxed but meticulous and sincere person. He wanted to adopt a child not only because he missed his two nephews but also because he wanted to help a child grow up with less of a struggle than he had had.

A 4-year-old boy was placed with Mr. R. He made a home just for the child and himself for 3 months so that they could get to know one another without other distractions. During this period he employed a part-time housekeeper, who came to the house early to prepare breakfast and take the child to nursery school. He even bought a car for the housekeeper's use. Later Mr. R and his son moved in with his mother, who assumed the responsibility of household management while Mr. R took over the task of taking his son to nursery school.

Mr. R spends a great deal of his leisure time in church activities. Through these he has met a woman whose company he enjoys and who he hopes will soon become the child's mother.

Because Mr. R and the 35 women without husbands to help them each took a child for adoption, 36 children who otherwise might never had achieved a feeling of permanence now have families of their own. Admittedly these families are incomplete, but they are "for keeps." Only with some assurance of permanence can a child develop a basic sense of trust.

Undoubtedly the incompleteness of a one-parent home presents some difficulties for the parent and the child. But these difficulties need not be regarded as insurmountable obstacles to healthy child development. They can be compensated for to a large degree by support from the parent's relatives and friends and by other persons in the community.

Evaluation planned

The Los Angeles County Department of Adoptions has shown that many persons without marital partners do have a great deal to offer children and that they will do so when given an opportunity. The review of these 36 case records strongly suggests that the children involved have found true "familiness." It does not tell us, of course, anything about how the children are responding to the experience. Only time can tell—time for the children to grow up and for the agency to make a careful evaluation of their adjustment at periodic intervals.

The Department is now planning such a longitudinal study. When completed it could have important implications not only for adoption policy but also for an understanding of the strengths and weaknesses of one-parent families of all types.

At the present time, the Department is making fewer one-parent placements than it did a few years ago because more couples are applying for children to adopt. More couples are asking for Negro children, although not yet enough to take care of all the Negro children needing adoption. The supply of families for other hard-to-place children fluctuates.

The one-parent home is just one resource for helping to close the gap between available hard-to-place children and adoptive families. Communities committed to the welfare of their children will explore every feasible plan for providing children with adequate permanent care. The best plan for one child with special needs may be a single person who is especially qualified to meet those needs. A better plan for another child, who feels secure with his foster parents, may be to encourage the foster parents to keep the child on an agreed upon permanent basis or to grant them a subsidy so that they can afford to adopt the child. When the luxury of choice is available, the placement worker can think through the alternatives so as to best meet the needs of the child to be served.

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A SERVICE PATTERN FOR HELPING UNMARRIED PREGNANT TEENAGERS

RUTH R. MIDDLEMAN

In this article I shall try to make the case, theoretically and illustratively, that really helping the unmarried pregnant teenager calls for dramatic, innovative service patterns and relationships that have a forceful impact. I make no claim that my thinking has been put to the test of research. Rather, it springs from my own work and the work of my social work students over several years in trying to help pregnant teenagers.[1,2]

My two central themes are: (1) work, and (2) meaningful communication. I shall discuss *work*, not in the usual sense of employment but as a vital dynamic in the pregnant teenager's search for relatedness to others, to things, and to the continuity of her own life. I shall discuss *communication* as the avenue through which others may help her achieve this relatedness. Although these two themes could be explored or examined separately, I will show how they merge and interact with one another as the helping process unfolds. The helping relationship evolves through the work and the work evolves through the helping relationship.

What then are the major tasks of the unmarried pregnant teenager? Erik Erikson, in his theory that everyone encounters a series of eight developmental crises in the course of growth from infancy through old age,[3] provides a clue. For example, he has described the crisis of adolescence as establishing one's own *identity;* the crisis of young adulthood as developing *intimacy* in relationships; and the crisis of adulthood as *generativity*, or creating and nurturing new life. At each period of life the human being must resolve the developmental crisis through mastering certain tasks.[3,4]

The teenager faces what is perhaps the most tormenting crisis of all—the establishment of identity. Who am I? What am I like? What will I become? What will become of me? These questions plague every teenager. The unmarried pregnant teenager is no exception. She is first and foremost a teenager—hard as this fact is for some adults to remember as they see her body bulging with new life.

While she shares the identity crisis with other teenagers, the pregnant teenager also has plunged herself—at least physically—into the demands of adulthood. She has one foot mired in what Erikson calls the identity crisis and the other foot in the crisis of generativity. In between is the vast terrain of the crisis of intimacy which she has not touched.

The unmarried pregnant teenager must achieve some sense of her own identity so that she can—if she so chooses—become a mother to her child. She needs to make concrete plans for the range of realities that mothering entails. Beyond this, the unmarried pregnant girl desperately needs to back up and reenter the developmental continuum at the point where she left off. This means reaffirming her identity and then moving on to experience the real intimacy of young adulthood. Only then might her second encounter with generativity be a satisfying adult experience.

Thus the pregnant teenager has a lot of work to do. All too often she doesn't even know it. Furthermore, the changes in her physical self and social status drive her into isolation.

As part of a study of black, pregnant teenagers in a hospital's outpatient clinic, I selected eight who were pregnant for the first time to participate in a group experience. I found them frightened and resistant in response to the unplanned birth. A wide range of forces pressed upon them. They brought fears about the bodily changes of pregnancy and the unknown birth process. They feared physical pain. They also feared the hospital and its many unfamiliar procedures and people.

Many of the girls felt isolated from their boyfriends. Many felt guilty because they had not lived up to their mothers' hopes that their daughters would somehow be different from themselves. All of them were reluctant to look at the social aspects, the nonphysiological part of their situation. They had come to the clinic for medical supervision of their pregnancy.

At my first group meeting, I found these pregnant teenagers guarded and resistant, full of "yeses" and silences. They seemed willing to listen to what I wished to say but not willing to become involved themselves. Because they were black, I wondered whether their reluctance came from the fact that I was white.

Subsequently, I learned that Gola Tatum, a black social worker, faced the same problem of resistance in attempting to initiate a combination of individual and group social services for black pregnant teenagers in a community health center. When she met with a continuing education class of 16 girls ranging from 12 to 17 years of age, she found:

> There was no conversing among the girls and muted munching of sandwiches and aimless shifting of book pages, and heads hung down and eyes dropped. The girls seemed to have made a solitary confinement of the classroom . . . .

Mrs. Tatum returned the next week to help the group plan a Christmas party. Again, the girls' remoteness and resistance were obvious:

> They were hesitant about speaking out and continuously looked back and forth at each other and dropped their heads. It took 15 minutes to vigorously twist out the first suggestion. Another 20 minutes passed before they reluctantly completed the plans for their Christmas party. By the end of our discussion, the girls appeared guardedly excited about the coming event.

Perhaps the fact that neither Mrs. Tatum's group nor mine welcomed the social worker suggests the need for a different way of reaching out to pregnant teenagers.

In my work at the clinic, I have tried to avoid beginning stalemates by using an approach that I feel is more congenial to an interchange between the unmarried pregnant girls and myself. At each meeting I introduce a task for them to work on—a task that is explicitly related to their engagement with each other and with me in the context of the hospital at one particular point in time. Helen H. Perlman has written of the underlying values of school work in the same sense in which I see the value of group tasks:

> School work provides the child's first experiences of required self-discipline in line with a planned and regularized program and sequence of tasks, of putting himself into doing things with his eyes and ears and head and hands. If these are well done, they give him a sense of knowing and mastery and accomplishment. If unhappily he cannot "do the work," for whatever reasons, he is left feeling inept, discouraged, and socially shamed.[5]

I have found that if the group activities can begin around a means of communication less threatening than words—that is, if the initial task is related to the previous experience or current interest of the participants—then communication can occur with less anxiety and group members will speak with less self-consciousness.

For the series of weekly meetings I selected a sequence of tasks, one for each session, through which my helping relationship with my group would develop. I tried to convey nonverbally my expectation that the girls would express their feelings, attitudes, values, and conflicts as they performed each task.

The first task was to take action about the physical changes of pregnancy. Upon meeting the girls I asked them to change out of their good clothes into green surgeons' gowns. Playing soul music as a background, I then showed them simple exercises—originally developed by physicians and nurses—that are helpful for relaxation during pregnancy and delivery.

I deliberately adapted the movements to involve the members of the group with each other in pairs. My purpose was to develop, through action, a supportive group culture. The participants held hands, helped each other with balance, and watched their partners' progress. As they began doing the exercises, they usually began to talk with each other and then with me. They talked about how well they were doing the exercises, whether and where they could do them at home, and how often they could do them. After this experience, it was easy for them to begin to talk during a sitting-down time about what they were eating, how they might be able to watch their weight and why they should, how they could eat and do their best in other ways for the baby growing inside them. They seemed very much interested in talking about caring for themselves rather than only thinking about the baby or their "problem."

In the second session the following week I began with questions about how their exercises were going. I found again that the girls did not have much inclination to talk. I then presented another simple task: I asked them to draw a map. *My objective was to help them see the connection between themselves, the hospital, and their present situation.* I asked them to show in one corner of the picture the building in which they lived, to put the hospital at the corner

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across the page, and to show in between how they came from their neighborhoods to the hospital.

After they finished their maps, I asked them to talk to each other in groups of two or three to find out more about each other—for example, Who comes to the hospital on the subway? Who lives farthest away? I found that the concreteness of this experience brought something familiar to an unfamiliar situation. At least the girls felt in control of what they were to do in regard to this piece of work.

After the first mapmaking I asked them to make other maps having to do with their present experience together—for example, a map of the first floor of the hospital with various hospital workers on it, or a map of a baby's room. At some time during this mapmaking (which I was careful not to call "drawing" or "art"), their questions, worries, opinions, and feelings began to come out. We then dispensed with the mapmaking and focused our attention on discussion. The initiative for the questions rested with the teenagers, who were quick to seize the opportunity to explore their concerns.

Events in the second session of the group illustrate the impact of such a mapmaking experience on the girls. Five members of the group, two girlfriends (not pregnant) of one of them who had come along to provide support, and a 4-year-old boy for whom one of the girls was babysitter, were there. With only a little encouragement from me, all the pregnant girls became involved in the mapmaking. The verbal interchange between one girl, Jean, and myself sparked participation by all the girls in an important discussion that grew out of and—to my delight—eclipsed the drawing experience.

On one page Jean drew a picture of her neighborhood. She showed her apartment with its street number. Next door was a large store with a "Rummage Sale" sign in the window.

In the store were stacks of used books marked 10 to 25 cents and a dress on a manikin. In addition, this picture included a bus passing the "White Doom Tower" and two autos. At the bus stop waited Jean—her belly visibly round—and her two girlfriends, looking very trim, who had come to the meeting with her. At the top of the page was an arrow with the words, "over for hospital." On the back of the page was depicted the entrance of the hospital with two tall doors, and "me entering" above a walking figure.

Jean talked about these pictures as she drew them, directing her remarks to me. She asked whether she should put down her due dates "Aug.-Sept. 30," and I encouraged her to do this. Suddenly realizing that she would have a different profile then, she set about erasing and changing her drawing, saying, "I'll need bigger breasts then and a different shaped belly." The whole group was watching, listening, and giggling, as Jean proudly waved the changed picture about and admired her own work. The group members then moved spontaneously into a discussion of many issues that concerned them.

They asked the following questions: Who else is due when I am? Will we meet at the front door of the hospital? (Laughter.) Can we be roommates? What kind of a room will we be in? How many people will be in the room? Can our boyfriends visit us? Can we have many visitors? Can anyone else watch the birth of the baby? Are you alone when you are in labor? Is it true that you are paralyzed from the waist down with a needle? What kind of way do they put you to sleep? Are you knocked out when the baby comes or do you see him? Are you on your stomach or back?

I responded to these questions according to their manifest content, answering them simply and correcting misinformation when necessary. At the same time I was careful not to deride the folk myths the teenagers had learned from their mothers. For example, after several girls said they had been told that fright would disfigure the unborn child, we discussed the question of whether or not they should watch a "scary movie" during pregnancy.

Many of the teenagers' questions concerned the physical pain of childbirth and their fear of it. One, worried that "all my insides will be taken out," wanted to know when this would be necessary.

At this meeting we made arrangements to take a trip together later through the maternity floor so that each member of the group would be familiar with her surroundings when she entered the hospital.

In our discusssions I tried to stick closely to the concerns the girls voiced. Mainly, I tried to convey a feeling of comfort about the naturalness of their questions, encouragement to talk about the worries that they had not mentioned before, readiness to hear their fears, and an openness to think about facts rather than hearsay. As these young expectant teenagers grew more free to discuss their concerns in the group, they also became more free to raise questions with their physicians.

I maintained my concrete approach through subsequent meetings. At one point, I introduced a board game called "Baby's Coming," which I designed to focus attention on the problem of unwed motherhood. The game deals with the range of issues set in motion by the pregnancy of an unmarried teenager. Because this content is very serious, I conceive of the game as work. *The task the game demands is that of facing up to life.*

Playing a game

"Baby's Coming" simulates the interconnection of all the people who became involved with each other because of the pregnancy of an unmarried teenager—the pregnant teenager herself, the unmarried father of her expected child, the pregnant teenager's mother, the social worker, and the doctor. Each participant in the game chooses a role to play; the most popular roles are "unmarried mother," "unmarried father," and "your mother." The players take turns throwing the dice to determine their moves on the board. When a player lands on a spot, she encounters a situation that is a piece of the problem. She must read the situation card aloud, and then must choose a response. For example, at the first spot the teenager's mother is presented with the situation: "You think your daughter is pregnant." The five possible responses are scored as follows: "You are not surprised; you've expected this" (−5); "You don't sleep as well at night," (+1); "You watch her more closely, including her personal habits," (+5); "You pretend you're imagining this," (−1); "You ask her if she is," (+10). Each choice contains a statement elaborating the consequences. For example, if the player selects "You ask her if she is," the statement is "This is facing things squarely."

As the movement through the game progresses, the consequences of each choice determines the player's progress toward winning. Through the activity of the different players, all the players can see their situation objectified in a simulated experience rather than hear it discussed by an adult authority, however sympathetically that adult may present the issue. I have found that pregnant teenagers try to pick out what they believe is the "right" thing to do, not necessarily what they *would* do. But I am not troubled if they figure out how to "con" the game, for meanwhile they are learning that such actions as staying in school, planning ahead, or considering others are rewarding types of behavior.

Communication

These exercises, mapmaking, and games, then, are the tasks I have used to bridge the communication barriers that, all too often, separate the would-be helper from the person seeking help. My view of work is a many-faceted one. It includes a concept of work as the focal point for the communication between the helper and the one being helped. When the communication is focused on a task, the unmarried pregnant girl comes face to face with her situation, and tries to deal with it, however reluctantly. The work for the helper is to become engaged with the girl in this effort, offering her support in such a way that she will want to work on the issues surrounding her pregnancy. Perlman has described the work-dynamic for man:

> Work should provide not simply the means by which man earns his daily bread but also the means by which he can express, nurture, and find himself . . . . the involvement of the child in actions that make some impression upon others or objects—these, when they yield to his effort, are his proofs of mastery. This is how the child—and later the man—knows his strength.[5]

Elsewhere I have discussed the similarity in dynamics between the concepts of work and play.[6] Often the main difference lies in how a person feels about what he is doing: for some, playing can be work; for others, working can be like play. In the group I have described, work seems to have become more engrossing for the members because the initial tasks were simplified and made relatively comfortable for them. The basic work—action-oriented tasks related to the central problem of pregnancy out of wedlock—led to effective verbal communication.

Thus, the work itself was the form of communication—both nonverbal and verbal—in the group sessions described. By moving from nonverbal to verbal methods, the girls were able to communicate with me more quickly. Mrs. Tatum has confirmed this point in describing her experience in the community health program:

> The film I had planned to show at this first meeting could not be shown. I walked around contemplating for about

> 5 minutes what I could do to get a nontalking, unresponsive group of timid, ashamed, unmarried pregnant teenage girls to forget momentarily or relax and act like other teenage girls. I immediately went into a brief discussion on verbal and nonverbal communication, and how this was important to our relationship and getting to know each other.
>
> I asked for three reluctant volunteers to do a skit in which a daughter asks a mother and father for money for a new party dress. This broke the ice, and the girls were slowly on their way toward partial participation. I acted out a shopping skit with another girl, using "vegetables" to show the importance and influence of nonverbal communication [through facial expression, gestures, tone, and pattern of emphasis] and this "cracked them up."
>
> I requested that each girl move her chair away from her table and form a semicircle, because most of them appeared to be holding onto their chairs for life. They were then asked to play tic-tac-toe using nine girls' names and finding out two things about these girls. It was amazing that many girls had been going to class together for months and had never met each other. All of the girls were completely involved with each other, laughing and talking, acting alive and young . . .

I believe all persons who offer services to others—especially middle-class persons—need to reconsider the blockages in communication inherent in their verbal emphasis. In addition to being skilled in picking up the nonverbal clues to the clients' feelings—posture, pauses, body movements, tone, and so forth—the helper must learn how to make the most of his own nonverbal methods of communicating to the clients. He must reach out on many congruent levels at the same time if he wishes to be understood and be perceived as a person who really cares. This need to communicate at many levels holds true for all types of exchanges—even among persons of similar backgrounds—staff interactions, for example.

Stuart Chase long ago emphasized how incongruities and resultant misunderstandings can becloud one's meaning in verbal exchanges.[7] The dilemma is heightened when the exchange is between persons of different socioeconomic classes, whose vocabularies may include many words with meanings outside the experience of the listener.

A recent study on the communication of emotions and meanings shows that even when the words used are clearly understood by both parties, the verbal part of a spoken message has little effect on whether a listener feels liked or disliked.[8] The verbal content of communication accounts only for 7 percent of the total effect. The balance of the meaning is conveyed facially—55 percent—and vocally by intonation, tone, stress, length, and frequency of pauses—38 percent. An exclusively verbal approach thus becomes a serious limitation for social workers, teachers, doctors, nurses, and others.[9]

My activities in serving groups of pregnant teenage girls encourage me to believe that through the wider use of the methods I have described, many grave problems might be faced more squarely by persons who are uncomfortable and reticent in a one-to-one interview or in a strictly verbal group discussion. My major focus is on concrete tasks—activities especially tailored to involve the skills, understanding, and previous experiences of the person being helped. But these tasks are only a point of departure in the communication process. Once the human connection is made, I find that the problem of verbalization is less of a barrier to meaningful exchange.

A concept of work was introduced at the outset of this article by my reference to Erikson's developmental crisis. In this frame of reference, "work"—that is, mastering the tasks involved in resolving the crises—is the problem situation around which the helping process forms.

Even Freud, when asked what he thought a normal person should be able to do well, replied simply, "Lieben und arbeiten" (to love and to work).[10]

Those of us who are engaged in service to others have, I believe, paid much attention to the love part of Freud's formula and far too little to the work part. Work, in the broad sense presented here, is a powerful means offered to those seeking help: through work they can discover their capacities, display their powers, and gain some sense of their limitations.

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THE RIGHTS OF FOSTER PARENTS

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In recent years there has been a growing movement among foster parents to form their own organizations, usually with the help and often at the instigation of the social agencies that place children with them. These organizations have a dual purpose: (1) To discuss the common problems of caring for other people's children; and (2) to raise the status of foster parents as carriers of one of the three major roles in foster care, the other two being the roles of the placement agency and the child's own parents. Increasingly such organizations have been focusing attention on foster parents' legal and moral rights and responsibilities.

What are the rights of foster parents?

We present here, with no implications of priority, a tentative list and are inviting the readers of CHILDREN to submit additions or revisions in preparation for a forthcoming National Conference of Foster Parents to be sponsored by the Children's Bureau, Office of Child Development, October, 1970. As presented, it incorporates many of the points made by Judith Gordon, child welfare supervisor for the San Francisco Department of Social Services, at a foster parents' institute convened by the Foster Parents United Association of San Francisco, October 18, 1969, and by George Goldmark, foster home developer in the same department, in reporting on the institute.

Foster parents' rights

Foster parents have a right to—

1. *A clear understanding of their role as foster parents* and the roles of the natural parents and the placement agency in respect to the child in care.

2. *Respect, consideration, trust, and valuation* as an agency employee or volunteer who is making an important contribution to the agency's objectives.

3. *Involvement in all the agency's crucial decisions regarding the foster child,* as team members who have pertinent information based on their day-to-day knowledge of the children in care.

4. *Freedom from built-in failure,* through not being asked to care for a child whose needs they cannot meet.

5. *Continuation* of their own family patterns and routines.

6. *Support from the social worker* in efforts to do a better day-to-day job in caring for the child and in working to achieve the agency's objectives for the child and his family, through provisions of—

    a. *Pertinent information about the child and his family.*

    b. *Help in using appropriate resources* to meet the child's needs.

    c. *Direct interviews between the social worker and the child,* previously discussed and understood by the foster parents.

    d. *Consultation regarding specific problems of the child.*

    e. *Information regarding the child's progress after he leaves* the foster family's home and opportunity—as indicated and desired—to have continued constructive contacts with the child.

7. *Opportunity to develop confidence in making immediate and day-to-day decisions* in regard to the child.

8. *Consideration as possible permanent parents* for the child who, after being in their home for some time, becomes free for adoption or permanent foster family care.

9. *Opportunity to learn and grow* in their vocation.

10. *Opportunity to be listened to regarding agency practices* that they may question.

11. *Full reimbursement for costs* of the foster child's care.

12. *Salary and all fringe benefits* available to other agency staff members.

13. *All rights accorded the agency's personnel,* including a procedure for a fair hearing and liability coverage.

Responsibilities

For every right there is, of course, a counterpart responsibility that is an integral part of the foster parents' overall responsibility to further the agency's goals for the child. Whether the child is to be returned to his own parents, to be placed for adoption, to go into some other type of foster care, or to remain with the foster parents until ready for self-dependence, the foster parents have a major responsibility for preparing him for what lies ahead. If the goal is to return the child, this responsibility includes encouraging contacts between the child and his own parents rather than becoming a barrier between them.

an essay review

PIAGET'S THEORIES and EARLY CHILDHOOD EDUCATION

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The developmental theories of the noted Swiss psychologist, Jean Piaget, have been made more comprehensible by the recent publication in this country of four books * that present much needed explanations of his theory of the development of intelligence.

Perhaps the most notable of the four is Piaget's "The Psychology of the Child," in which he has attempted to summarize his developmental theories in a single concise volume. This book, along with Ginsburg and Opper's "Piaget's Theory of Intellectual Development—An Introduction" and Beard's "An Outline of Piaget's Developmental Psychology for Students and Teachers," which are also primarily summaries of Piaget, are welcome additions to the literature on learning. These publications should prove especially helpful to persons seeking a first acquaintance with Piaget since his developmental theory is spread over numerous volumes and articles, many of which make difficult reading and some of which are available only in French.

"The Psychology of the Child" should help to dispel some of the mystique that has come to surround Piaget's theories—often because of a basic misunderstanding of his theoretical standpoint and also because of his difficult writing style. Piaget begins by making clear that his book has to do with "genetic epistemology" and not directly with "child psychology." According to Piaget, the difference is that child psychology is the study of the child for its own sake, whereas genetic epistemology is the study of the child for the purpose of solving problems relating to the origins of knowledge, intelligence, and logic.

In his work, Piaget has taken up the problem of the origin of ideas and attempted to determine the relationship between experience gained through the senses and the logical structures of intelligence. Perhaps much of the misunderstanding of Piaget begins with the mistaken idea that he is addressing himself to the more conventional research problems of the child psychologist.

Piaget's theory of learning is unlike the learning theories of experimental child psychologists in being oriented toward the development of the structure of intelligence. As Ginsburg and Opper so aptly point out, Piaget distinguishes between two types of learning: (1) The learning of specific responses to specific situations; and (2) the development of cognitive structures of intelligence and higher levels of assimilation. Conventional child psychologists are concerned with the former; Piaget with the latter.

A developmental theory

In "The Psychology of the Child" Piaget enumerates four primary influences on intellectual development and consequently on learning: (1) The child's physical structure, that is, the body and its functions; (2) experience, in the form of activity, involving interaction of the child with his environment; (3) social experiences involving the learning of behavior related to a specific sociocultural environment; and (4) the self-regulatory mechanism, "equilibrium," which produces a balance between the assimilation of new experiences and accommodation of them to what is already known at any given developmental level.

Piaget, as the four summaries make clear, is primarily interested in building a theory of the structure of intelligence through experimental investigation. His theory of intelligence is concerned with three underlying factors: Content, function (or operation), and structure.

The content of intelligence consists of the data gained through sensory motor experience. The function or operation of intelligence consists of an inherited manner of dealing with the environment involving two primary processes: *Organization* of the existing cognitive structures and *adaptation* of new experiences (including assimilation and accommodation).

The structures of intelligence are the series of cognitive structures that Piaget calls schemata. Each schema is a concept of reality based on the generalization and differentiation of repeated xperiences.

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*THE PSYCHOLOGY OF THE CHILD. Jean Piaget and Barbel Inhelder. Basic Books, New York, N.Y. 10016. 1969. 173 pp. $5.95. THE MECHANISMS OF PERCEPTION. Jean Piaget. Basic Books, New York, N.Y. 10016. 1969. 480 pp. $12.50. PIAGET'S THEORY OF INTELLECTUAL DEVELOPMENT—AN INTRODUCTION. Herbert Ginsburg and Sylvia Opper. Prentice-Hall, Inc., Englewood Cliffs, N.J. 07632. 1969. 237 pp. $2.95, paperback; $6.95, clothbound. AN OUTLINE OF PIAGET'S DEVELOPMENTAL PSYCHOLOGY FOR STUDENTS AND TEACHERS. Ruth M. Beard. Basic Books, New York, N.Y. 10016. 1969. 139 pp. $4.95.

Learning, according to Piaget, involves the construction, organization, and alteration of existing schemata to orm new schemata that incorporate more complex cognitive sequences at the action, symbolic, and operational evels of development.

In Piaget's theory of development, perception occurs in conjunction with sensory-motor activities and intellectual operations but does not account primarily for the growth of intelligence. In "The Mechanism of Perception," Piaget suggests two possible hypotheses regarding the relationship of intelligence to perception: (1) a direct connection between perceptions and cognitive structures by means of sensory-motor activities, and (2) "the autonomous development of intelligence from action (sensory-motor activities), accompanied by a continuous enrichment of perceptual structures under the influence of the development of structures of action and of intelligence." Piaget adopts the latter hypothesis for several reasons, including his finding that "notions originate in sets of actions and operations which begin with sensory-motor organization, of which perceptual activities represent only a particular sector."

Thus, Piaget places perception in a subsidiary role in learning compared with sensory-motor and operational activities.

The role of motivation in Piagetian theory is somewhat akin to the "competence" theory of R. W. White.[1] Both suggest that the motive for learning is to gain mastery or competence in relation to the environment. In Piaget's theory, motivation for learning is not the need to achieve a goal deemed worthy by external standards, nor the need to reduce tension, but rather the intrinsic need to exercise the assimilation-accommodation processes for the purpose of developing cognitive structures for dealing with the environment.

Some effects

One result of Piaget's developmental theories has been the recognition of the crucial effect of early childhood experiences and the importance of early childhood education in the development of the child.

Perhaps the major attempt to translate the developmental theories of Piaget into some kind of a theory of instruction has been the work of Jerome Bruner,[2] who has focused on those factors in Piaget's formulations that appear to be within the control of the psychologist and the educator—the structure of the environment and the arrangement of the proper "match" between the individual developmental level and the environment. Bruner's concept of intelligence is perhaps best explained in his theory of "instrumental conceptualism." The general framework of the theory is similar to Piaget's "assimilation–accommodation" model, although, in attempting to relate his model to psychology and education, Bruner has placed a much greater emphasis on *psychological processes* (such as memory and transfer of training to learning) and the structure of the environment.

Bruner's concern with "the match"—that is, matching teaching methods to the child's stage of development—has been translated into his theorem of readiness: ". . . any subject can be taught effectively in some intellectually honest form . . . to any child at any stage of development." [2] This statement has often been interpreted to mean that Bruner is in essential disagreement with Piaget regarding the necessity of age-bound (as opposed to sequence-bound) stages of development. On the contrary, Bruner accepts the invariant sequence of the stages, but seems to regard the age-bound nature of the stages as a general description of what might occur on the average.

Misinterpretations of Bruner arise from failure to recognize that any subject can be taught to any child *only* when the method of instruction is in accord with the child's developmental level. Teaching a subject involves teaching it in one of three cognitive modes comparable to the three major stages of Piagetian development: (1) sensory-motor, (2) perceptual, and (3) operational. Although a child may not understand or be ready to learn a concept at the operational or logical level, he may be ready for basic "understanding" of it, in the form of sensory-motor manipulation or perceptual experience. This suggests that a challenge for research in early childhood education is in the development of educational experiences, materials, and methods to provide the specific kinds of sensory-motor and perceptual experiences that facilitate progress toward operational thinking.

In the absence of knowledge based on such research, many early childhood educators have attempted "crash programs" to bring so-called "culturally disadvantaged" children up to the norm. Piaget's sequential theory of intelligence suggests that such programs may be doomed to failure because they may not be developing the kinds of skills that will build upon one another in the sequence of sensory-motor, perceptual, and operational levels. They attempt to rush into a particular subject matter with symbolic methods that may not be transferrable to other subject areas. Piaget (or Bruner) might argue that the culturally disadvantaged should be taught in the same sequential fashion as other children. For example, to understand algebra on the operational level the child would need first to have engaged in some sensory-motor activities that would give him a practical basis for understanding the meaning of the algebraic symbols.

Implications

One of the notable aspects of both the Ginsburg-Opper and the Beard volumes is the attempt to present some of the implications of Piaget's theories for education.

Ginsburg and Opper suggest the following educational guidelines based on Piagetian theory:

1. Since the language and thought of the child are qualitatively different from the adult's, the teacher should attempt to determine how they are different, or, more specifically, the level of intelligence at which the child is operating. Attempts have been made to put this idea to practice by encouraging children to learn through exploration and discovery (discovery-learning) and through experiments, such as those at the Ontario Institute for Educational Studies that are concerned with the match between the conceptual levels of pupil and teacher.[3]

2. Children learn best from activity. According to Piaget (and also John Dewey), learning is doing, and the child makes substantial progress when he has abundant opportunities for sensory-motor activities. Perhaps then, the major challenge for early childhood educators is the determination of the *specific*

activities that constitute a proper background for developing such conceptual activities as language and logic. Much research remains to be done in this area.

3. With regard to achievement motivation, Piaget's theory suggests that the notion of "interest" is primarily an intrinsic quality dependent on the degree to which the subject matter presented to the child is related to his level of intelligence or to what he already knows. Piaget postulates the self-accommodation process, the natural flow to equilibrium between new learning and what is already known, and the natural exercise of cognitive structures under appropriate stimulation. These assumptions lead him to suggest that "the child is more apt to modify his cognitive structures in a constructive way when he *controls* his own learning" then when rewards for learning come primarily from external sources.

Some recent research seems to bolster the theory that motivation is based, in part, on the child's perception of himself as the *locus of control* for his actions.[4]

At the present state of early childhood education, the implications of Piaget's theories, while important, are of a most general nature. However, the general application of Piagetian theory may eventually be translated into knowledge and control of the specific psychological processes of stage transition.

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[1] White, R. W.: Motivation reconsidered: the concept of competence. *Psychological Review*, 1959.

[2] Bruner, Jerome S.: The process of education. Vintage Books, New York, N.Y., 1960.

[3] Harvey, O. J.; Hunt, David E.; Schroder, Harold M.: Conceptual systems and personality organization. John Wiley & Sons, New York, N.Y., 1961.

[4] deCharms, R.: Personal causation. Rotter, Julian: Psychological monographs. No. 1, 80, 1966.

GUIDES and REPORTS

HUNGER: an action guide. Marguerite Gilstrap. National Board of the Young Women's Christian Association, 600 Lexington Avenue, New York, N.Y. 10022. 1969. 16 pp. 40 cents; five or more copies, 35 cents each.

Outlines steps that local organizations can take to create public awareness of hunger and malnutrition, to learn about programs of food assistance in their areas, and to spearhead action to secure such programs where they are not available.

MINNESOTA SYMPOSIA ON CHILD PSYCHOLOGY, VOLUME 3, John P. Hill, editor. University of Minnesota Press, Minneapolis, Minn. 55414. 1969. 163 pp. $5.

Includes six papers presented at the third annual Minnesota symposium on child psychology, sponsored by the Institute on Child Psychology, University of Minnesota. They report research dealing with stimulus familiarization, early stimulation and cognitive development, stimulus selection, the implications of animal studies, natural reference groups during adolescence, and components of sibling interaction.

CHANGING SERVICES FOR CHANGING CLIENTS. Columbia University Press, 440 West 110th Street, New York, N.Y. 10025, for the National Association of Social Workers. 1969. 127 pp. $3 (paperback).

Includes selected papers discussing the effects of social changes on people, on social services, and on the delivery of services.

ADDENDA TO STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES. National Council for Homemaker Services, Inc., 1740 Broadway, New York, N.Y. 10019. 1969. 32 pp. $1.

Presents additional standards to those published by the National Council for Homemaker Services in 1965.

PRELUDE TO ACTION: report of the Maternity Center Association's 50th anniversary seminar on childbearing and family life, held March 31–April 3, 1968, at the Princeton Inn, Princeton, N.J. Maternity Center Association, 48 East 92d Street, New York, N.Y. 10028. 1969. 170 pp. $3.

Contains summaries of five group discussions presented at a seminar on the problems of providing maternity care and ways these might be solved.

THE FUNCTION OF REBELLION—IS YOUTH CREATING NEW FAMILY VALUES? Child Study Association of America, 9 East 89th Street, New York, N.Y. 10028. 1969. 83 pp. $2.45.

Proceedings of the Child Study Association's 1968 conference, designed to explore the roots and aims of today's rebellious youth and the responsibility of adults and social institutions for opening meaningful channels of communication between the generations.

EASTER SEAL GUIDE TO SPECIAL CAMPING PROGRAMS. Helen Crane, editor. Task Force on Special Camping, National Easter Seal Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago, Ill. 60612. 1969. 106 pp. $1.50.

Offers guidelines for the development and administration of special camping programs for handicapped children.

THE ROLE OF THE OPHTHALMOLOGIST IN DYSLEXIA. Institute for Development of Educational Activities, Inc., Box 446, Melbourne, Fla. 32901. 1969. $1.

Reports on a seminar designed to clarify some of the confusion surrounding dyslexia, or learning disabilities, and to determine the ophthalmologist's role in diagnosis and treatment.

BOOK NOTES

PROTECTION OF VISION IN CHILDREN. Arnall Patz, M.D., and Richard E. Hoover, M.D. Charles C Thomas, Publisher. Springfield, Ill. 1969. 171 pp. $10.

Addressed to pediatricians, family physicians, paramedical workers, school officials, volunteers, parents, and teachers who deal with children, this book presents principles and methods of prevention, early detection, and management of visual problems. The authors, both faculty members of the Johns Hopkins University School of Medicine, emphasize the importance of detection of visual defects in preschool children to allow proper treatment at a time when chances for success are greatest.

Recently developed screening tests, management of the child with severe visual impairment, and first-aid care of eye emergencies at school and at home are dicusssed. The book also describes the roles of the obstetrician, the pediatrician, the family physician, and the genetic counselor in prevention and detection of visual defects.

DELINQUENCY: Selected studies. Thorsten Sellin and Marvin E. Wolfgang, editors. John Wiley & Sons, Inc., New York, N.Y. 1969. 161 pp. $7.95.

The first chapter of this book describes an "index of delinquency" developed by the editors in the early 1960's to measure the amount and seriousness of juvenile offenses, taking into account both the number of law violations and their character and degree of seriousness. Taking police data on delinquency as the basis for the index, the editors questioned the validity of the principles of classification used in police reports and developed a new system of classification to reveal the variants within the usual classifications.

This book presents six studies of application of the index, carried out as extensions of the basic research, studies of: (1) the distance between a location of an offense committed by a person under 18 years of age and his home; (2) the ecology of juvenile delinquency; (3) the delinquency of gangs and spontaneous groups; (4) internecine conflict and characteristics of the offender; (5) factors that influence the police disposition of juvenile offenders; and (6) trends in robbery measured by different indexes.

The six studies made with the cooperation of the Police Department of Philadelphia were carried out by four former graduate students in criminology or sociology at the University of Pennsylvania, all of whom participated with the editors in the original research: Stanley Turner, Bernard Cohen, William H. Hoehstein, and Andre Normandeau.

THE CHILDREN: a personal record for the use of adoptive parents. Jan de Hartog. Atheneum Publishers, New York, N.Y. 1969. 265 pp. $6.50.

The joys and trials of adopting two Korean girls, 5 and 3 years of age, are described by writer Jan de Hartog in this collection of "random notes on the practical aspects of interracial adoptions." Drawing on his own experiences and those of more than a hundred couples in the United States who have adopted young Asian children of mixed parentage, the author discusses the arrival of the child, the everyday difficulties of settling down, and the gradual development of family life.

The author explores many of the problems that face the adopted child and his new parents: among others, the transition for both child and parents from the idealized picture of the new family to the realistic acceptance of other family members for their own sake, the child's need for security, the periods of "blind, witless panic" that affects parents in the first few weeks, the importance of routine, the confusion of too many choices, the differences in the way Asian and American children play. The author tells how he and his wife met some of these problems. When he felt guilty about spanking one of his adopted daughters, he was reminded by another adoptive father that "anger happens to be a proof of concern," and furthermore, "the knowledge that you care" is one of the greatest gifts a parent can give his child.

The author tells about some of the Asian children who seem to have adapted to a new family, but who have merely retreated into a secret world where "nothing touches them much." A child who has been so severely damaged emotionally may need considerable time to change, he says, but suddenly such a child will become "demanding, moody, jealous, and afflicted by the insatiable need for affection." He advises parents: "Make sure that after the battle of the day you give him what he really came for: lots of love and tenderness."

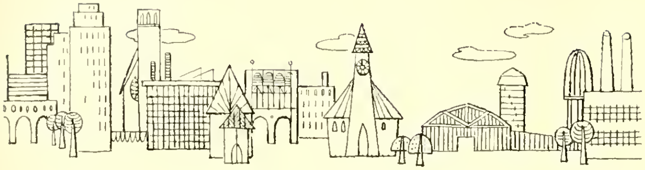
THE OTHER 23 HOURS. Albert E. Treischman, James K. Whittaker, and Larry K. Brendtro. Foreword by David Wineman. Aldine Publishing Co., Chicago, Ill. 1969. 240 pp. $7.

This book deals with the management of daily events in the lives of emotionally disturbed children in residential care—the 23 hours that such children spend outside of psychotherapy. It discusses ways that child care workers can use communication, social reinforcement, and "modeling"—that is, providing through their own behavior patterns that the child can imitate—to establish constructive relations with maladjusted children.

Chapters provide suggestions for program activities; managing the periods of waking up, mealtime, and bedtime; temper tantrums; and otherwise creating a therapeutic milieu. Methods of observing and recording children's behavior are also presented.

The authors give many illustrations from their work at the Walker Home for Children in Needham, Mass., a residential home for severely disturbed boys, and the University of Michigan Fresh Air Camp for emotionally disturbed delinquent children. They stress the importance of developing the technical skills and self-awareness of child care workers and at the same time "involving high-level personnel in everyday child life issues."

HERE and THERE



White House Conferences

About 15,000 persons are expected to attend six regional White House Conferences on Children to be held in November as precursors to the national conference, which is scheduled to meet in Washington, D.C., December 13–18, 1970. Some 3,000 delegates will attend the Washington meeting.

The regional conferences will be held in the following cities: Portland, Oreg., Denver, Colo., Omaha, Nebr., Indianapolis, Ind., Tampa, Fla., and Pittsburgh, Pa. Along with the Washington conference in December, they will be focused on the problems of children from birth through the age of 13.

People to participate in discussion panels for these conferences are now being selected by the conference staff in consultation with various State and national organizations. Material for their consideration is being developed from a variety of sources, including seminars and workshops currently being conducted at the conference headquarters in Washington, meetings held by the State committees on children and youth, and suggestions received from professional and voluntary organizations.

Ballots for the election of a chairman, vice chairman, and secretary for each regional conference were mailed in March to the 55 chairmen of State and Territory committees on children and youth. The final selections were made on April 15, 1970.

Preparation for the youth phase of the White House Conference to be held in Washington, D.C., in June 1971, is also underway. Approximately 120 summer interns are being selected through the Federal service entrance examination, the Washington intern program, the White House, the State committees on children and youth, and a special civil service program to include disadvantaged young people. They will work in three major areas: (1) Examination of Federal programs relating to youth; (2) research into issues that have particular impact on youth; and (3) communication with the various segments of the public interested in the White House Conference.

The examination of Federal programs that affect young people will be carried out by a youth task force headed by Frank D. Raines, now a junior at Harvard University. A staff of 60 young people, primarily college students, will work from June 15 to September 1 in Federal agencies concerned with nine specific areas: Education, employment, crime and justice, health, legal rights, the military and the draft, public service, consumer affairs, and recreation and environment.

The youth task force will determine which programs significantly affect youth, evaluate their effectiveness, recommend changes in current practice, and specify the kind of innovative action needed. Their findings will be presented to the administration for consideration in developing a national youth policy, according to Stephen Hess, chairman of the White House Conference. The formulation of such a policy was recommended to the President and his Cabinet by the staff of the Urban Affairs Council in September 1969.

Welfare rights

On March 23, 1970, the Supreme Court of the United States in a 5–3 decision ruled that public assistance payments, under either Federal-State programs or general relief programs, may not be stopped until recipients whose eligibility is in question have had opportunity for an evidentiary hearing. The ruling upheld a decision of a Federal district court in New York requiring New York City to hold hearings before cutting off public assistance payments and reversed a decision by a Federal court in California that sustained the State's practice of stopping public assistance payments after opportunity for a conference, but not a hearing.

In the majority opinion Justice William J. Brennan said that the hearings must give the recipient, among other things, a chance to be heard in person, to know on what evidence and reasons he is deemed ineligible, to cross-examine witnesses and to retain a lawyer if he chooses. Justice Brennan specifically pointed out that the Court was not saying that counsel must be provided for the recipient, but he noted that counsel could be helpful.

Child care

A 3-year, $3 million project to develop and demonstrate model day care programs in the eight Southeastern States is being launched this spring with the use of both Federal and private funds. State family and child welfare agencies in Alabama, Mississippi, Georgia, Florida, Kentucky, North Carolina, South Carolina, and Tennessee are participating. Each State's project will emphasize a different aspect of day care or other form of part-time child care.

The William H. Donner Foundatio of New York City is investing $250,00 a year in the programs and the Department of Health, Education, and Welfare is allocating a total of $750,000 a year under title IV–A of the Social Security Act, which provides for services t strengthen family life. States and localities are also contributing facilities services, and funds.

The Southern Regional Educatio Board of Atlanta, Ga., coordinator fo the project, is providing training an evaluation for all programs. SREB i working with a committee of official from eight States and the Office o Child Development and the Social an Rehabilitation Service of the Atlant regional office of HEW.

The programs will serve children fro 6 months to 14 years of age. The demonstrations include care for childre under 3 years of age, afterschool an overnight care, summer care, use o obile facilities, training and use of "loating" day care mothers who can o where needed, contracts with private gencies for comprehensive child care ervices, and use of citizens' advisory ommittees. All programs are designed o give the States experience in operating programs and in supervising operaons by public and private agencies to eet the needs of children and their amilies.

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A 2-day Conference on Industry and Day Care was held at the Center for Continuing Education, University of Chicago, on March 18–20. Sponsored by he Urban Research Corp. of Chicago, he conference brought together 125 epresentatives of industry, specialists n early childhood development, and Federal, State, and local officials to discuss ways in which the industries might provide day care services to the children of their employees.

In the keynote address, Henry Morgan, manager of human relations for the Polaroid Corp., described the demonstration day care project funded by the Children's Bureau of the KLH Co. in Cambridge, Mass., with which he had previously been associated. The conference also heard from representatives of AVCO Corp., Mr. Apparel Co., and the Skyland Textile Co., all of which have established day care centers in their plants.

Invited to raise what they considered to be major issues relating to industrial involvement in day care programs, the conferees brought up such questions as whether the best site for an industrial day care center was near the home or near the plant; whether the financial outlay required to provide day care is paid off in reduction of absenteeism and employee turnover; whether or not parent involvement in the day care program should be compulsory; what Federal funds are available for day care and how industries might qualify for them; and how industries can be educated to the broad social goals involved in providing constructive day care programs, rather than simply custodial care.

Small workshop groups discussed licensing requirements for facilities; program goals; the 4–C program, sponsored by the Office of Child Development to encourage coordination of local day care services for children; franchise arrangements; and ways in which industry, communities, and the Federal Government might cooperate in creating citywide model day care centers.

The conference concluded with talks by Jule M. Sugarman, acting director of the Office of Child Development, on the costs of day care and sources of funding, and by Congressman John Brademas of Indiana, chairman of the House Select Subcommittee on Education, on pending Federal legislation relating to day care.

Adoption

To help States build up adoption resources for black children and children of mixed racial background—where the gap between resources and need is greatest—the Children's Bureau is planning a nationwide recruitment effort.

As a first step, it has selected a group of skilled interviewers to talk with people in five large cities to secure their suggestions and opinions on ways of increasing the number of adoptive homes, and to determine their willingness to help in the development of a recruitment plan in their localities. Persons interviewed will include adoptive parents and representatives of social agencies, and organizations interested in the problem, including organized black groups.

Among other subjects to be discussed will be the potentialities of transracial adoptions and subsidized adoptions for helping to meet the problem. The cities in which the interviews will take place are New York, N.Y., Washington, D.C., Atlanta, Ga., Chicago, Ill., and Los Angeles, Calif.

After the results of the interviews are analyzed, a national committee will be formed to set up the machinery for stimulating local recruitment efforts to secure adoptive parents for black children and children of mixed racial background.

A similar project will be launched later to recruit adoptive homes for children with special needs, including physically and emotionally handicapped children, older children, and groups of children of the same family.

Children's teeth

No significant racial or geographic differences were found in a recent study comparing the amount of tooth decay in black teenagers and white teenagers in Detroit, Mich., and Columbia, S.C., according to a report made at the International Association for Dental Research in New York in mid-March. The study, carried out by Robert A. Bagramian, D.D.S., assistant professor of dentistry and public health at the University of Michigan, was originally designed to test the widely accepted theory that racial and geographic factors affect amounts of tooth decay.

At the time of the study, neither city's water supply contained fluoride. All of the young people examined—696 of both races in Detroit and 891 of both races in Columbia—were high school students who had grown up in the city in families of low socioeconomic status. Young people of both sexes were included. When the statistical findings of "caries experience" were broken down for eight groups—males of each race in each city, and females of each race in each city—all showed high averages of decayed, missing, or filled teeth per child:

- Black males in Detroit—9.45; white males in Detroit—10.85.
- Black males in Columbia—11.07; white males in Columbia—10.78.
- Black females in Detroit—9.78; white females in Detroit—11.59.
- Black females in Columbia—11.20; white females in Columbia—10.89.

In comparing his findings with the findings of studies estimating the incidence of caries experience in the black population as a whole, Dr. Bagramian found a higher incidence of caries experience among the black urban high school students. He suggests an explanation for this might be that the migration of Negroes from rural to urban areas has been accompanied by a change in diet patterns involving the ingestion of more sugar—a contributing factor in caries experience.

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The National Institute of Dental Research of the National Institutes of Health is planning a 10-year national caries program to make tooth decay almost completely preventable by 1980. According to the Institute, dental caries—or tooth decay—affects 98 percent of the people in the United States and is the most prevalent affliction of children. A child entering school has an average of three decayed teeth and a 15-year-old child has an average of 11 decayed teeth.

The national program will emphasize continued research into the cause, control, and prevention of caries and the development of techniques that can be incorporated into personal oral health programs and community health services. Based on the recommendations of a dental caries task force appointed in 1969 and the results of dental research conducted and supported by the Institute, the program will use three approaches to prevention of dental caries:

- *Protecting the teeth* through the development of new methods to provide fluoride to the 40 million Americans who do not now have access to fluoridated water supplies, including such means as the addition of fluoride to salt and the application of fluoride-containing gels to the teeth. Efforts will also be made to perfect adhesive sealants that protect the chewing surfaces of the teeth.
- *Modifying the diet* through the development of substitutes for ordinary table sugar; addition of phosphates to such foods as flour, salt, milk, and snacks; and further investigation of the preventive value of adding trace elements to foods and water.
- *Combating bacteria* through the use of enzymes to prevent or remove bacterial plaque—gummy masses of bacteria—and the application of antibiotics and antiseptics.

The national caries program will also focus attention on the need for tooth restoration, using new materials and tooth implants.

Rubella

In the first 8½ months of the nationwide "Stop Rubella" campaign coordinated by the Public Health Service, rubella vaccine was administered to about 4.8 million children, or just over 10 percent of the 44.5 million children in the United States within the target age group, according to the reports to the National Communicable Disease Center. The 5-year cooperative State-Federal campaign against rubella, which began July 1, 1969, is designed to vaccinate all children between 1 year of age and puberty (in most States, 11 years of age; in a few others, 10 years of age). Children are considered the main source of spread of rubella, a disease that may cause severe defects or death in the fetus of a pregnant woman. (See "Rubella and Its Aftermath," by Janet B. Hardy, CHILDREN, May–June 1969.)

Federal rubella grant funds have provided about 2.4 million doses of rubella vaccine, or half of the vaccine used in the campaign thus far. The other half has been provided under State or local funds and other Federal funds such as those available under title I of the Elementary and Secondary Education Act.

With the licensing of two additional types of rubella vaccine by the Department of Health, Education, and Welfare, the campaign will be accelerated within the coming months. Philips Roxane Laboratories of Columbus, Ohio, received the second license in December 1969 for a vaccine grown in canine tissue. The third license was granted in March 1970 to Recherche et Industrie Therapeutiques, a Belgian subsidiary of Smith Kline & French Laboratories of Philadelphia, Pa. The RIT vaccine is produced in rabbit kidney cell cultures. The first license was issued to Merck Sharp & Dohme of Rahway, N.J., in June 1969 for a vaccine grown in duck embryos.

Young parents

Ten young parents, age 20 or under, met in mid-March with members of the Subcommittee on Parent and Family Life Education of the Interdepartmental Committee on Children and Youth to consider the implications of teenage parenthood for government policy and for programs of family life education. They included four married couples, one married mother without her husband, and one unmarried mother. All had become parents before the age of 18. They came from the inner city, working class suburbs, the Army, and an Indian reservation.

In addition to the young parents the consultants to the subcommittee included two nongovernmental professional persons—a psychologist, Helen Southard of the staff of the National Board of the Young Women's Christian Association, and a sociologist, Jessie Bernard of Pennsylvania State University. James Lieberman of the National Institute of Mental Health and Carlotta Miles of Howard University led the discussion.

In spite of their differences in background, the young parents bore testimony to some common problems: economic difficulties generally; the catastrophic effects of medical expenses; the inability to afford decent housing; the lack of resources for good day care; the inability to pursue further educa tion; the lack of suitable opportunities the lack of information about resource to meet their problems. For example the medical expenses of pregnancy an childbirth had forced two of the men into taking moonlighting jobs.

Two young men in the group wh had Army experience spoke of the emas culating effects of not being able t meet their family responsibilities be cause of the restrictions of being i the military. Four of the five wome expressed the wish to plan an addi tional child and to limit their tota number of children to two.

All the young parents expressed re sentment at not being treated by societ as adults. For example, they had bee unable to get credit or take out medica insurance. They also expressed feeling of isolation from other young peopl with the same problems. Those wh were attending night school complaine that they were not being taught well nor really receiving much content: "no nearly as good as regular high school.

A full report of the meeting with com ments on its implications for govern ment programs, especially in relatio to family life education, is to be pub lished by the Children's Bureau in th near future.

Pediatric care

Comprehensive pediatric care is mor efficient and less costly to the patien in time, money, and dissatisfaction tha the fragmented care usually provide for the urban poor according to Joel J Alpert, M.D., Margaret Heagarty, M.D John Kosa, Ph. D., and Jean Robert son, Ph. D., as a result of a study the carried out in Boston, Mass., betwee 1965–69, with support from the Chi dren's Bureau.

Families who were users of the eme gency clinic of the Children's Hospita Medical Center, Boston, in 1964 wer eligible for the study provided the lived within 3 miles of the hospital, ha no physician who usually looked afte the children, expected to live in Bosto for 3 years, did not have a member wh presented a high probability of develo ing a chronic disease, and would agre to a series of interviews.

The 931 families eligible to partic pate in the study were divided a random into three groups: (1) an exerimental group offered comprehensive pediatric care, (2) a contact control group, and (3) a noncontact control group. Data were collected on the first two groups at 6-month intervals over the subsequent 3 years. Families in the third group, formed for assessing interview effect, had a brief initial interview and were not contacted again until he final data collection.

Analysis of the data showed the following significant results:

- Immunizations and other prevenive measures were higher in the experimental group.
- More health supervision visits were made by members of the experimental group.
- Fewer hospitalizations, surgical procedures, visits because of illness, and broken appointments occurred in the experimental group.
- Expressions of satisfaction occurred more often in the experimental than in the contact control group.
- Fewer laboratory procedures were provided members of the experimental group.

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A national Center for Research and Development in Early Education of Handicapped Children is being established at the University of Oregon in Eugene during 1970, under the Mental Retardation Facilities and Community Mental Health Centers Construction Act. The center is the first to be concerned specifically with research in the education of handicapped preschool children. It is the seventh research facility affiliated with the U.S. Office of Education's National Laboratory on Early Childhood Education, Urbana, Ill.

Services to children

About half of the requests for service received by 237 local voluntary and public child welfare and family service agencies during a 5-day period in May 1969 involved foster care or services to children in their own homes, according o a nationwide survey made by the Child Welfare League of America and supported by the Children's Bureau. Conducted by Ann W. Shyne, CWLA director of research, and Lucille J. Grow, research associate, the survey was designed to provide information for use in research planning.

Of the 3,748 total requests for service on behalf of 6,256 children, 23 percent were made for foster care; another 23 percent, for services to children in their own homes; 9 percent, for adoption service (predominately for white children); 8 percent, for day care (predominately for Negro children); 7 percent, for maternity home care; 6 percent, for homemaker service; and 20 percent, for a variety of other services, such as summer camping.

In about half the cases, the agencies planned to provide the specific service requested. About one-fifth of the requests were referred to other agencies, with referral somewhat more common for Negro clients.

The median age of the children for whom service was requested was 8.5 years, with 21 percent less than 3 years of age and 33 percent 12 years of age or older. The majority of requests—68 percent—were for services for white families; 22 percent of the requests were for Negro families.

Parents made 44 percent of the requests for service: health and welfare agencies, 26 percent; relatives, friends, and neighbors, 10 percent; the courts and police, 6 percent; schools, 6 percent; and other persons, 8 percent. Among both public and voluntary agencies, the courts were most effective in initiating service for a child; relatives, friends, or neighbors were least effective.

Reasons given to the agencies for the need for service included: emotional or behavior problem of the child, 35 percent; pregnancy out of wedlock, 11 percent; birth out of wedlock, 10 percent; illness, death, or confinement of parent, 9 percent; child abuse or neglect, 8 percent; financial need, 6 percent; parental conflict, 4 percent; other reasons, 17 percent.

Negroes made 44 percent of the requests for service received by the 13 participating public agencies, but only 16 percent of those received by the 224 voluntary agencies. A much smaller proportion of Negro families than white families sought either maternity home care or adoption service. On the basis of their findings, the researchers suggest that the voluntary agency is still regarded by its clients and the community at large as providing service primarily for the white child.

The report of the study, entitled "Requests for Child Welfare Services: A Five-Day Census," is available from Research Center, Child Welfare League of America, Inc., 44 East 23d Street, New York, N.Y. 10010. (Price: $2.)

Miscellaneous

"Jenny Is a Good Thing," an 18-minute color film produced for Project Head Start and narrated by Burt Lancaster, shows children eating, cooking, learning about food, gardening, and learning new words, colors and concepts of size, and shape, and texture through nutrition-related activities. Using children of various ethnic backgrounds, it was filmed at Head Start centers in Jacksonville, Fla.; Vincennes, Ind.; Cochiti Pueblo and Santa Fe, N. Mex.

The film was nominated for an academy award in the documentary category.

The 16-mm. film is available in English and Spanish for a 5-day rent-free loan from Modern Talking Picture Services Film Libraries in United States and Canada. It may be purchased from Precision Film Laboratories, Inc., 21 West 46th Street, New York, N.Y. 10036, for $45 per print.

A leader's discussion guide, designed to be used with the film is available from the Office of Child Development (Publication 3E in the Head Start Nutrition Kit).

• • •

Maternal and Child Health Service, Public Health Service, has recently begun publishing a bulletin, *Maternal and Child Health Information*, designed for the exchange of information affecting the maternal and child health field. The first four issues of the bulletin, which is to appear irregularly, have reported on the implications for maternal and child health of three national conferences recently held in Washington, D.C.—a conference on maternity and infant care projects, a conference on pregnant teenagers, and the White House Conference on Food and Nutrition—and on trends in maternal and child health services, the MCHS budgetary requests for 1971, and other items bearing on health needs and services for children.

The bulletin is available without charge from Public Health Service, Health Services and Mental Health Administration, Maternal and Child Health Service, Parklawn Building, Rockville, Md. 20852.

IN THE JOURNALS

Foster care

A number of child welfare agencies are offering new understanding of the possibilities of permanent and long-term foster family care for children who must live with substitute parents for long periods during their growing years, say Bernice Madison, Ph. D., and Michael Schapiro, in the March 1970 issue of *Child Welfare*. ("Permanent and Long-Term Foster Family Care as a Planned Service.") The authors are respectively professor and associate professor of social work at San Francisco State College.

In the past, return of the child to his own home—even when parents were not ready to assume responsibility—and adoption have been considered preferable to planned foster family care, the authors explain. Pointing out that this limited choice has often led to unplanned temporary foster family care that continues for many years, they suggest that it is the poor quality of such unplanned long-term foster care—rather than the type of care itself—that has added to the children's emotional damage while in substitute homes.

Defining "long term" care as care for children who are in the custody of an agency for an extended period but whose guardianship has not been surrendered by their natural parents, and "permanent" care as care for children who are legal wards of the State and who have been transferred to an agency's guardianship, the authors explain that these differences affect the procedures but not the fundamental substance of arrangement for a child's care. They note that many children can be neither returned home nor adopted.

Pointing out that most children coming into foster care for the first time are less than 3 years of age, the authors emphasize the importance of an early decision on whether the care is to be temporary or whether the child is to be in the agency's care on a permanent or long-term basis, and—if it is to be either long term or permanent—that plans be made accordingly.

To protect the security of the child, the authors advocate the establishment of a policy requiring that once a child has been absorbed into a permanent foster family that is giving him adequate care, he is no longer available for adoption except by his foster parents. The authors report that some agencies are finding oral or written contracts with the foster parents useful in creating a feeling of permanence and security in both foster parents and child; they maintain that the quality of the discussion around permanent planning is the key to its effectiveness.

Adolescents in 1970

The majority of today's adolescents accept the established institutions of American society, play out the roles assigned to them by family, education, and occupation, and subscribe to traditional values, yet they are different from adolescents of the past, says Kenneth Keniston, director of the Behavior Sciences Study Center of Yale University School of Medicine, in the January 1970 issue of *Clinical Proceedings of Children's Hospital of the District of Columbia.* ("The Adolescent in 1970.")

To explain the psychological development of today's youth, the author cites two factors: (1) the extension of adolescence as a developmental phase, and (2) the exhaustion of the credibility of the moral values of our society through the success of technological production.

As a socially recognized and valued stage of life, adolescence is a modern concept that emerges only in our own century, the author notes. He points to economic advances that have freed many adolescents from the need to d adult work while achieving the psychological, intellectual, and technical qualities valued by society. Thus, he says today's adolescents have an opportunity to develop themselves, with all of the agony and possibility for growth that this involves.

The author points out that some of society's values, such as the Protestant ethic that once buttressed industrial production, no longer seem relevant to many young men and women brought up in families where material plenty social status, and political freedom are taken for granted. He describes a turning away from old values of self-control self-discipline, and achievement and a search for new values among the young He explains that while in some areas American society has failed, in other areas it has exceeded its earlier targets and—lacking new targets—it has become exhausted by its success. "As a result, this is an era that brings an unprecedented and surprising upsurge in youthful discontent," he observes.

Nursing the retarded

A theory of nursing in institutions for mentally retarded children and adults that encompasses educational as well as medical functions is proposed by E Gene Patterson, consultant to the National Association for Retarded Children, and G. Thomas Rowland, professor of early childhood education at New York University, in the March 1970 issue of *American Journal of Nursing* ("Toward a Theory of Mental Retardation Nursing: An Educational Model.") The authors define the job of the nurse who works with mentally retarded patients as interdisciplinary in nature involving skills derived from both physical and behavioral sciences but neither dependent on nor parallel to the practice of medicine.

According to the authors, retardation—although often physiologic in origin—is essentially a matter of decelerated or impaired cognitive functioning that in many instances is responsive to certain types of educational programs. They stress the urgency of creating a better climate within residential facilities for the mentally retarded to reduce the dehumanizing situations that result in a waste of human potential. Such a climate should encourage development

ithin the triad of *personal adequacy*,
ocial competency, and *economic effi-*
ency, they explain, adding, "It re-
uires the fostering of maximal auton-
ny on the part of the retardate."

Looking at nursing of the retarded
the foregoing context, the authors
fer a new job description "written in
rms of nursing rather than medicine."
hey suggest that their model views
ursing "as having regard for the hu-
an being's efforts to establish order in
e environment and for use of the
stablished order as a basis for the de-
elopment of intelligent behavior."

esidence requirements

The decision of the Supreme Court
f the United States in April 1969 de-
laring unconstitutional all State resi-
ence requirements for eligibility for
ublic assistance has brought no radi-
al changes in State public assistance
aseloads, maintain Norman V. Lourie
nd Stanley J. Brody, J. D., in the January 1970 issue of the quarterly, *Public Welfare*. ("Implications of Recent U.S. Supreme Court Decisions on Residence Requirements.") The authors, deputy secretary of Public Welfare for Pennsylvania and associate professor of social planning at the University of Pennsylvania School of Medicine, respectively, queried State welfare agencies after the Court decision about trends in public assistance payments to recipients who previously would have been classed as nonresident.

Of the 35 States and four other jurisdictions that responded, the number of nonresident recipients who were added to the rolls "somewhat" balanced the number of recipients residing in other States for whom payments were discontinued, according to the authors. Six States that had eliminated residence requirements before the Supreme Court decision reported an increase of 0.01 to 2 percent in nonresident recipients in their total caseloads resulting from elimination of the residency requirement. Pointing out that almost 50 percent of nonresident applicants in one State live in rural areas, the authors suggest that public assistance may be the partial solution to the "deep poverty" of migrant farm laborers.

In reviewing research in migration, the authors note that the most common reasons people give for moving are promises of employment and the presence of relatives in their new locality. They found that States with high levels of public assistance payments did not attract a disproportionate number of nonresidents. Pointing out that the pattern of movement in public assistance recipients is almost identical with the movement of the general population, they predict that interregional and national migration will increase. They stress their view that migration is a "normal human crisis," causing individual and family problems that the public welfare field has a responsibility to alleviate.

READERS' EXCHANGE

DOWNEY: some omissions

I would like to comment on some points made in John Downey's article in the January–February issue of CHILDREN, "Why Children Are in Jail and How To Keep Them Out," which reports a Children's Bureau study of detention in 10 States and 13 individual counties. In general the conclusions of this study support the long-held conviction of the National Council on Crime and Delinquency (NCCD) that the detention of children, whether in jail or out of it, is misused by the juvenile courts of America.

Mr. Downey's solution to the problem is to pass laws prohibiting the use of jails for juveniles without exceptions, and to provide physical alternatives to the jail. He correctly advises the establishment of: (*a*) nonsecure group homes for children who need emergency care, but not secure custody, and (*b*) overnight to 48-hour secure emergency facilities apart from the jail for children who need to be detained temporarily under continual adult supervision while arrangements are made for their release or their transfer to a regional detention center. Mr. Downey implies but does not stress that these facilities ought to be established, and available, before jail detention for children is legally prohibited. Severe penalties should be attached to such a prohibition. Otherwise such legislation will invite the continued violation of law by the very agencies which exercise authority over juvenile law violators.

Perhaps Mr. Downey did not think it necessary to point out the ill effects of child jailing to the readers of CHILDREN. Many people, however, believe that there is nothing wrong in jailing children as long as they are separated from adult prisoners, and their belief is supported by most State statutes. On the contrary, not only is the child's "delinquent self image" strengthened in jail, but too often separation from adults results either in their solitary confinement (which sometimes ends in suicide) or in their being physically and sexually assaulted by older and stronger youth for lack of supervision—even by adult prisoners.

Physical facilities are not the only alternative to the use of jail for children. NCCD's nationwide survey for the President's Crime Commission found that nearly half the children referred to juvenile courts had not committed the kinds of offenses that bring adults to trial and that more than half of those remaining were more in need of protective and preventive services than secure custody. Probation rarely provides this.

Few communities have established Youth Service Bureaus to identify the problems of these youngsters, coordinate community resources on their behalf, and see that they get help in resolving problems that contribute to their delinquency. Realistic resources for young people who are hard to reach with normal services are in short supply. Moreover, social agencies tend to reject youngsters who are involved with the juvenile justice system.

It is high time that States and communities took responsibility to fill gaps in community services for these young people instead of passing the buck to the court. NCCD will soon publish guides for Youth Service Bureaus that can coordinate and strengthen local services on behalf of young people who are more in need of assistance than jailing.

An up-to-date bibliography of detention materials, including *Standards and Guides*, is available upon request from the National Council on Crime and Delinquency.

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KATZ: *changing parents' attitudes*

"The most important question for a preschool teacher to ask herself concerning her role, style, and goals may be: *What am I doing to increase the mothers' confidence in the future of their children?*" This sentence, from the final paragraph of Lilian Katz's article, sums up one of the two provocative issues the author raises in her thoughtful, research-oriented discussion of the roles, styles, and goals of preschool teachers. ("Teaching in Preschools: Roles and Goals," by Lilian G. Katz, CHILDREN, March-April 1970.)

First, Dr. Katz points out that such research as we have indicates that parents, given a choice, tend to prefer a control-oriented role model for teachers over three other models: Content-oriented, discovery-oriented, and sympathy-oriented. Furthermore, she reports, the younger the child, the more the parent is likely to prefer a "control-oriented" teacher. Few preschool teachers would feel this is an appropriate role model.

The difference between mothers' and teachers' ideas of teaching may depend basically upon what Jane Loevinger wrote of some time ago as "implicit theories of learning." Perhaps the parents are affected by the old Protestant ethic—the assumption that a child should do what his parents wish him to do because it is the right thing for the child to do. Reward is not to be provided by what one ought to do, anyway, but punishment is to be provided for transgressions.

It has been my experience, and that of my fellow workers as we have spent time with parents of young children, that it is difficult, although not impossible, to change parents' preference for control-orientation to one more inclined to positive reward. After guided observation in our classroom for a dozen mornings, one of our low-income mothers suddenly said: "I guess this shows you really don't need to beat kids to get them to learn."

A pitiably small insight, perhaps, but its slowness in coming would suggest how deeply entrenched is the control model, and a conviction that punishment is the way to change behavior. Working closely with parents in our groups, we have tried to help them see that a child in a preschool setting can acquire a skill and the understanding important to the parent, and how it can be done, and done more effectively, through a positive rather than a negative method of control.

Establishing this kind of working relationship with the parent may well be the preschool teacher's most important role of the future. We should be grateful to Lilian Katz for making the point so clearly.

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international publications

WORKLOADS IN CHILDREN'S DEPARTMENTS. Eleanor Grey. Her Majesty's Stationery Office, London, England. U.S. distributor: Sales Section, British Information Services, 845 Third Avenue, New York, N.Y. 10022. 1969. 75 pp. $1.50.

This is a report of a time study of staff time in the children's departments of authorities (county welfare departments) in England and Wales operating services to children under the British Children's Act of 1948.

GENETIC FACTORS IN CONGENITAL MALFORMATIONS: report of a WHO Scientific Group. World Health Organization Technical Report Series. U.S. distributor: American Public Health Association, Inc., 1740 Broadway, New York, N.Y. 10019. 1970. No. 438. 42 pp. $1.

This report examines the part played by genetic factors in some of the more common birth defects, the etiology of which is still poorly understood—such as cleft lip and cleft palate, dislocation of the hip, and spina bifida.

These conditions are examined in respect to their familial incidence, the effect of sex on the risk of recurrence, the relation of the risk of recurrence to population frequency, the effect of the migration of populations, and interracial crossing.

CHILDREN'S GAMES IN STREET AND PLAYGROUND. Iona and Pete Opie. Oxford University Press, New York, N.Y. 1969. 317 pp. $9.50.

Games that British children pla spontaneously without equipment o adult supervision are described in thi book, which lists 2,500 names for game that are popular among 6- to 12-year olds. The authors obtained many versions of active nonsinging games from about 10,000 school children during a 10 year study that ended in 1969.

The authors have grouped the game by activity: chasing, catching, seeking hunting, racing, duelling, exerting, dan ing, guessing, acting, and pretending The book includes rhymes spoken dur ing play, histories of traditional games and comparisons of the similaritie between British games and those o other countries.

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ublications for which prices are quoted are for sale by the Superintendent of Docu-ents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be companied by payment. Twenty-five percent discount on quantities of 100 or more.

UICIDE AMONG YOUTH: a review of the literature, 1900–67. Richard H. Seiden, Ph.D., HEW, PHS, National Institute of Mental Health. PHS publication No. 1971. 1969. 65 pp. 65 cents.

Discusses the epidemiology of suicide mong adolescents and reviews pub-shed studies of adolescent suicidal be-avior, with tables, figures, and ibliography; issued as a supplement to he *Bulletin of Suicidology.*

EENAGERS DISCUSS THE "GENERATION GAP." Elizabeth Herzog, Cecelia E. Sudia, Barbara Rosengard, and Jane Harwood. HEW, OCD, Children's Bureau. Youth Reports No. 1. 1970. 36 pp. Free from OCD.

Presents the first in a series of Chil-lren's Bureau reports of the opinions f young people on problems that con-ern them, based on 251 returns from ail survey, or 63 percent of a panel f high school students enrolled in col-ege preparatory courses in 12 metropolitan areas. Includes summaries of the opinions with excerpts from the teenagers' correspondence.

HEALTH SERVICES FOR MOTHERS AND CHILDREN under title V, Social Security Act. HEW, PHS, Maternal and Child Health Service, Rockville, Md. 20852. Publication OM–2074. 1969. 11 pp. Free from MCHS.

Describes grant programs related to the health of children administered by the Maternal and Child Health Service, Health Services and Mental Health Administration, including Federal-State programs for maternal and child health and crippled children's services; special projects for maternity and infant care, the health of preschool and school-age children, and dental health of children; personnel training; and research.

HOW TO PLAN A DRUG ABUSE EDUCATION WORKSHOP FOR TEACHERS. HEW, PHS, National Institute of Mental Health. PHS Publication No. 1962. 1969. 35 pp. 25 cents.

Presents guidelines for planning and conducting various types of inservice training for teachers on drug education, developed by two affiliates of the National Education Association—the American Association for Health, Physical Education, and Recreation, and the National Science Teachers Association.

CAREER OPPORTUNITIES IN SERVICE TO THE DISADVANTAGED AND HANDICAPPED. Sponsored by HEW. HEW, Office of Education. Publication No. OE 37039. 1969. 39 pp. 30 cents.

Lists training programs supported by agencies within the Department of Health, Education, and Welfare for persons interested in serving the disadvantaged and handicapped.

NUTRITION EDUCATION FOR YOUNG CHILDREN: adventures in learning—a guide for teachers and aides. Nutrition Publication 3F. 1969. HEW, OCD, Project Head Start (Washington, D.C. 20201). 64 pp. Free from OCD.

Presents suggestions about helping young children learn about food and how to establish good food habits, with recipes and projects suitable for children's use in Head Start.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; SRS, to Social and Rehabilitation Service; PHS, to Public Health Service.

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children

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children

Helping Parents Get What They Want
A Learning Disability Clinic
Group Homes for Delinquent Boys
Health Care Through Head Start

VOLUME 17 • NUMBER 4 • JULY–AUGUST 1970

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

This young enrollee of a Head Start child development center is being examined by a physician as part of a continuing program of health supervision. Head Start's efforts to see that children get comprehensive health care are described in the article beginning on page 149.

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Some concerned people say there may be 5,000 mentally retarded children in the New Orleans area who are not receiving any special care other than that which their parents are able to provide at home. This estimate may not be too large, judging by the number of such children living in a disadvantaged area of the city inappropriately called Desire. Most of these children have been evaluated by means of psychological testing, excused from attending classes in public school, and then as far as schooling goes, relegated to a file to await an opening in some special institution or in the special classes provided by the Orleans Parish School Board.

Awareness of these children prompted the Tulane University School of Social Work to assign one of its students to work with parents of retarded children in the Desire community during the school term 1968–69. A first year student at the school that year, I received the assignment. My efforts began with a focus in group counseling but gradually were transformed to helping the parents achieve what they wanted—schooling for their children.

The important thing for me in taking on this assignment was to learn how to work with a group. However, the parents' primary motivation for attending biweekly meetings was not their desire to participate in group counseling but their eternal search for school placement for their retarded child. Since my plans were constantly revised by events as well as by the learning process, I will here present a month-by-month report of what transpired.

November

Since no organized group of parents of retarded children existed in Desire, the first step was to go out and find them. My field instructor was able to put me in touch with the parents of one retarded child. My work began with a visit to this family.

For many years this family had been frustrated by being unable to find an appropriate educational placement for its severely retarded child, but eventually the child had been accepted in a special institution from which he returns home on weekends. Although satisfied with this placement, the parents expressed interest in participating in a group counseling experience. However, after the group was formed they never attended any of the meetings. Nevertheless, by saying "yes" to my project, they had set fire to my zeal to search for more parents for my group.

From the Association for Retarded Children of Greater New Orleans, I learned of 20 parents of retarded children in the Desire area. However, because

a LEARNING EXPERIENCE in HELPING PARENTS GET WHAT THEY WANT

JOHN BOYLE

f the social work principle of confidentiality of inormation, I was not permitted to contact these people irectly. Instead, members of the association's staff rote to the parents to tell them of the planned group eetings and recommend that they get in touch with e at the Tulane Social Service Unit in Desire. I aited for their phone calls and letters. Of the 20 arents, only one contacted me, even though the assoiation followed up the letters with phone calls.

This meager response suggests certain questions: id the parents have any idea of what we meant by roup counseling? Is group counseling enough to ffer parents burdened with the day-to-day care of a etarded child? Apparently these parents felt no eed for it. Do such parents have to have some hope f getting concrete help from a group before they ill be moved to join it?

The next place I turned to was the Desire Comunity Center. When I inquired if there were parents f retarded children in Desire, they assured me there ere many and that the public welfare workers asigned to the area knew most of them. A public elfare worker gave me the names of four families. visited each of these families in addition to the one amily that had responded to the association's conacts. In these face-to-face encounters I discovered hat each family was deeply concerned about its rearded child and the lack of an educational resource or him. At least one parent in each family agreed to ome to the group counseling meetings.

By the end of November parents of six families in which there were retarded children had agreed to attend a meeting scheduled for December 2. These "parents" included one grandfather; all the rest were mothers, most of them of one-parent families.

December

The first meeting of the parents' group was held in early December at the Community Center, at the invitation of the center's director. This became the locale of all the meetings, which were scheduled every 2 weeks.

Only two parents came to the first December meeting and one of them had left before the second one arrived. At the second meeting four parents arrived, all on time. Because I wanted them to get to know each other well enough to become a group, I encouraged them to tell each other about their retarded children and their difficulties in finding schooling.

The parents talked freely about the children and offered mutual understanding and support to each other. I explained that this was what group counseling was all about: To be helpful to one another in defining their problems and in reaching out for solutions to these problems. However, it became clear that these parents did not need group counseling to define their problem. They all had the same problem, and they knew what it was—to find a school where their child could learn something. Until this was accomplished, no other problem seemed worth tackling. From the very first meeting the parents changed the focus of interest from group counseling to school placement of their children. No one could yet conceive of how this might be achieved, but there was no doubt about school placement being their objective.

During December I anxiously tried to get more people to join the group and extended my efforts to the nearby lower ninth ward. But later I learned of so many parents with retarded children in Desire that my efforts to bring in more parents from the lower ninth ceased. I hoped, however, that a parents' group could eventually be developed there.

January

In January the Association for Retarded Children began referring all new applicants for their services from Desire directly to me. I learned of other families with retarded children through public welfare workers, staff members of the community center, and members of the parents' group itself. Because I now had the names of more people than I could visit, I contacted all of them by letter and by telephone inviting them to attend the January meetings.

During January and February attendance at the meetings ran from four to five parents. The only "parent" who attended regularly, however, was an elderly grandfather of two retarded children. At each meeting there were always new faces, so that I usually went through the routine of asking the parents about the special problems of their children. This turned out to be a good method for opening up communication between the group members.

January was a time of much uncertainty about the goals and direction of the group. The parents continued to provide each other with moral support, to air their problems, and to give school placement priority in their concern, but they still could see no way to achieve this objective. The result was a general feeling of frustration for all of us. I sensed that the parents were regarding me with misgivings for having called them together but failing to offer hope for a solution to their most pressing problem. I myself could see no solution to that problem.

During this time my field instructor and I were still concerned about the development of group counseling, but we could see little possibility of achieving this objective if the parents' most basic problem was not faced. I had a strong feeling that the parents as a group would have greater potential for dealing with the problem of school placement than they would individually. I also kept in mind that in building a group we were building power that could eventually be strengthened through a coalition with similar groups in other parts of the city. I felt that such a coalition could be effective in dealing with the school board and feeding information about mental retardation to the planning for a Model Cities program. However, only my field instructor's assurances that we were passing through the normal process of group formation and her efforts to encourage me to keep the group aware of its potential for development kept me from feeling completely frustrated at this time. Also the sense of helplessness engendered by the school problem raised my own and the parents' anger, and this motivated us to carry on.

My field instructor also helped me see that the group had to find some meaningful activity to keep up its attendance. When I brought this up at a meeting, the members decided that the group would only be effective if it were stronger and that it needed more members to become stronger. So by the beginning of February it had a plan of action—to recruit more parents.

February

Although attendance at the meetings remained small and irregular, the members of the group were working on the recruitment plan. More people were joining. The group as a whole was becoming large and stronger, making it more possible to do something. But the "something" remained vague. I found myself constantly repeating the statement that very little had ever been accomplished by persons who worked alone and that accomplishment depended on becoming a large, strong, and coherent group. Th members seemed to agree with that and the group held together.

Other things began to happen. News of the grou began to spread. It came to the attention of the recently formed Professional Association for Retarded and Disadvantaged Children, which was concerned with the problems of retarded black children i New Orleans. Representatives of this association approached the Desire Community Center and th Tulane Social Service Unit to discuss the possibility of setting up a school for retarded children in Desire. They also attended one of the meetings of ou parents' group to describe their goal. Although th association's efforts came to naught, it gave new hop and a new vision to the parents' group. From the on the members never ceased talking of establishin their own community school for retarded childre in Desire. I tried to keep before them the idea tha ch a school might be a temporary solution to their oblem, but that it would be very difficult to keep . I began developing my own battle cry about every ild's right to a free public education. The parents re always ready to say "Amen" to that.

One of the members of the Professional Association r Retarded and Disadvantaged Children was an thusiastic young man who had grown up in the esire public housing project and who was now orking under the New Careers program as a acher's aide in a school for retarded children in other part of the city. He suggested that our group art a Saturday Club, following a model that had en used for retarded children in that area. The ub would bring together the area's retarded chil-ren every Saturday morning. There would be classes, creation, and a light snack for them.

The group responded with enthusiasm and the oung man who made the suggestions assumed re-ponsibility for running the class. The community nter made its entire building available for the chil-ren on Saturday mornings. A volunteer at the public elfare agency who was working with a retarded ild joined the parents' group and helped with the aturday program. Some regular staff members at e center dropped in on Saturdays to work with the ildren. Four students from Southern University orked as volunteers.

The Saturday Club grew to a regular attendance of out 12 children and nearly as many volunteer staff embers, thus permitting one-to-one interaction be-veen each child and a concerned adult. When I left e Desire area in May 1969 it was still going strong.

The creation of the Saturday Club was the first ngible evidence for the parents in the group that mething could be done for their children. However, ey participated very little in its formation and peration although they had made the need for it vident, and heartily approved of it. At one time they talked about providing the food for the children's snacks, but they never did. They had not originated the idea, they had not helped plan the program, and they had no role in carrying it out. All this left me feeling somewhat concerned.

The parents were succeeding, however, in the one task they had taken on for themselves—getting new members. By February the total group included 15 parents. But because of the irregular attendance, the meetings were never that large. Some parents apparently joined the group from a desire to support its goals rather than from any intention to attend the meetings regularly.

March

Because the biweekly meetings of the group were not well attended, we decided at the last February meeting to schedule the March meetings on Saturday at 9 a.m. We reasoned that holding the meetings on Saturday, which was not a workday for most parents, would boost attendance. But it did not turn out that way. During the whole month of March and the first part of April, no parents showed up for the meetings although notices had been sent to all the members. These overburdened parents apparently felt they could not take time to attend a meeting that they still seemed to feel would not have tangible results.

In this period the group reached its lowest ebb of activity. For me, however, it was a period of increased activity on the parents' behalf. I felt I had to get some things moving toward the establishment of a school for retarded children to revive their interest in the group.

In the meantime the Professional Association for Retarded and Disadvantaged Children was engaged in an effort to raise enough money to hire certified teachers in special education. The association had been assured of getting teacher's aides from the New Careers program. The community center had agreed to furnish space for a 5-day-a-week school for retarded children. Moves were being made in the right direction. But the association was not able to raise the necessary funds.

At this time when I was uncertain about what was going on and what could possibly come of it all, the Tulane Social Service Unit in the Desire area was conducting a series of seminars for students who had been assigned to the area. We were to discuss our own groups, and to analyze and evaluate the group process in which we were involved. As I was describing the growth and development of the parents' group, the projection of its goals, and the involve-

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ohn Boyle worked in the community center escribed in this article while earning his aster's degree at the Tulane School of ocial Work. A lay religious of the Congre-ation of Holy Cross, he is now organizing n innercity neighborhood council in Daven-ort, Iowa. Mr. Boyle spent 3 years in razil as a full-time moderator of a national udent team doing organizational work on behalf of the atholic "left." Previously he had taught French in high hools in Brazil and the United States. He did his under-raduate work at the University of Notre Dame in Indiana.

ment of many community resources in its concerns, it began to dawn on me that I really had something going. The encouragement I received from my fellow students and my instructor helped me recognize that the group of parents of retarded children in Desire represented a real potential for social change in the community.

April

April brought some hopeful lights on the horizon. The director of the community center told me of a national meeting of the Council of Foundations in New Orleans. Nine representatives of foundations would be visiting the center on April 10 to hear about the self-help programs in Desire. Although the council had been assured that its members would not be approached for grants, the message did not get through. They were bombarded with concrete proposals from 15 local groups, including one from the Desire Community Center for money to establish a school for retarded children.

The president of the Association for the Aid of Crippled Children of New York expressed an interest in this proposal and gave me his card. A few days later I wrote him to inquire how the center should go about applying for a grant from his foundation. In reply I was asked for a description of the requirements for the teachers in the school. I wrote the description and forwarded it at once, but when I left Desire at the end of May, the foundation had not yet responded.

The New Orleans Association for Retarded Children called my attention to the possibility of getting a staffing grant for the proposed school through the Department of Health, Education, and Welfare. One look at the long and complicated application form, and the knowledge that matching funds of 25 percent of total cost would have to come from local sources, made such a grant seem impossible. I did nothing about it. But the association had already told an HEW regional representative about the parents' group in Desire. The middle of April marked the beginning of a series of telephone calls from the consultant for mental retardation in HEW's regional office in Dallas, Tex.

I pulled out the application form again and began to pour over it. It seems impossible, so I set about writing a proposal in my own words, setting forth the need and plan for a school for retarded children in Desire. The 25 percent in local matching funds had been promised by the board of the community center to meet the HEW requirement.

The writing of proposals was a new and instructive experience for me. I could not involve the parents, since they were not attending the scheduled meetings during March and most of April. But I did involve my Tulane field instructor since other students would have to participate in the project after I left. In the first drafts of both proposals I made an impassioned plea on behalf of the retarded children in the black community and included pointed references to what appeared to me to be neglect of the retarded children of the black community by supposedly responsible agencies in New Orleans.

There was a great contrast between my tendency to write in a wordy, emotionally charged, crusading style and the field instructor's point of view that effective proposals are concise, concrete, and contain nothing more than what one proposes to do. It took some adjusting, but we finally agreed on versions that were more concise than my originals.

However, the HEW consultant in Dallas was no satisfied. She encouraged us enthusiastically abou the proposal itself, but insisted that the long and complicated forms be filled out. The forms left little room for my weakness to be carried away by the cause and to forget the concrete requirements of th proposed project. However, I managed to complet them and send them to HEW before the end of April

Writing the proposals had very positive effects on me. It brought the Desire Community School out o the clouds of my passionate desire to "do good" fo the retarded children to a down-to-earth plan abou what would be necessary to achieve something worthwhile.

My greatest concern toward the end of April was that just as some light had appeared on the horizon the parents' group seemed to be passing out of existence. I talked about this with my field instructor and the other students in the field unit. We all agreed tha the parents should be visited and urged to attend the April 22 meeting. I could not make all these visit myself, so the students and the field instructor agreed to help. Consequently, each of the 15 families wa visited before the next meeting date. Six parents cam to the meeting.

At this meeting for the first time we could talk about the real possibility of opening a school for th retarded children in Desire by September 1, 1969. W discussed how much the parents would be able to pay to help support the school. It was agreed that the parents would contribute $1 a week. We began talking about what other space might be available if th school had more than one class, since that was all tha ould be housed at the Desire Community Center. he group suggested the Sunday school rooms of the cal Lutheran Church. I then contacted the pastor f the church. He gave his full support to the suggestion, joined the parents' group, and began attending its meetings regularly.

The end of April was marked by the revival of the arents' group, the continuation of the Saturday lub, and the raising of a high hope that funds would e forthcoming in time to open the Desire Community School for Exceptional Children in September.

May

Tulane field unit activities in May are all dominated by one idea—"termination." It was evident, owever, that the termination of my fieldwork in Desire could not mean the end of the parents' group or of the project to establish the Desire Community School for Exceptional Children. Plans to carry on Tulane's part in these efforts were worked out with he two field instructors in the area. The first year ield instructor agreed to carry the meetings during he period between the end of the spring semester and he beginning of the summer semester. The second year field instructor agreed to find another student who would work with the group during the summer and fall.

During May four parents attended one of the two group meetings and five parents the other. The parents all agreed that the group must continue to meet after my departure. They again assumed the task of getting more parents to join the group and more who were already members to come out for the meetings. By early June, 30 parents belonged to the group.

On May 12, staff members of the local Model Cities program began holding weekly meetings in Desire to discuss problems of education and social services with the local citizens. It was an excellent opportunity to feed into the Model Cities planning some information about the problem of mental retardation. Each week I contacted one or more of the parents in our group to encourage them to go to these meetings. However, nobody from the group attended the Model Cities meetings in May.

On May 19, I had my last meeting with the parents' group. I introduced them to the field instructor who would be with them for the next few meetings. I expressed to the members my satisfaction in having worked with them and assured them that the group could reach its objectives if they kept working at it.

On May 20, the Tulane Social Service Unit in Desire held its annual "roundup" at which the students presented a review of their work during the year. I was late for the roundup because the HEW consultant for mental retardation from Dallas was on the phone again saying what a great proposal we had sent in. She added that it would have to be completed with a curriculum plan and a job description for all the personnel to be involved in the project. These matters were taken care of promptly, but not by me. Thank heavens for field instructors! The rest of my week was taken up with final exams.

Some questions

In summary, the experience in getting parents of retarded children together, originally for group counseling, had resulted in attention being called to a grave social problem in the community, the involvement of local and remote resources in efforts to reach some solution of the problem, and the distinct possibility that a concrete response to that problem would be achieved. But the experience left me with many unanswered questions.

Were these developments all an accident? Or do they indicate that Tulane University, its school of social work, and the school field unit can play a unique and irreplaceable role in community development in Desire?

What *is* the role of poor, disadvantaged people in defining community problems, setting goals, and executing programs that will answer their needs? It seemed hard to find a meaningful role for them in the school project, but would it have been possible without the parents' participation? What more could they have done?

Just how much of what is called group process really happened in the development of the Concerned Parents for Retarded Children in Desire? It is such a loose-knit, on-again, off-again group, and carries on such little activity, how is it going to develop in the future? Will it be able to assume control and responsibility for the Desire Community School for Exceptional Children?

Above all, I ask questions about my own role as community organizer. Was I really the center of this little whirlwind, churning it along with the power of my own indignation at the plight of the retarded children of Desire? Did I involve local and nonlocal resources as much as possible in developing the project? Certainly the Concerned Parents for Retarded Children should have been more involved, but how?

And I keep asking myself the rhetorical questions: Doesn't every child have a right to free public education? Even a retarded child?

EPILOGUE

Mr. Boyle's fieldwork in the Tulane Social Service Unit in Desire ended in May 1969. However, his enthusiasm for involving neighborhood people in efforts to meet a community need was reflected in the activities that followed.

During May and June both field instructors at the Tulane unit, the director of the Desire Community Center, and a member of the staff of the Greater New Orleans Association for Retarded Children worked together to complete the application to HEW, with the enthusiastic support of HEW's regional consultant for mental retardation.

Early in July we were advised that HEW had approved a grant for staffing the Desire Community School for Exceptional Children based on a $14,638 budget for the first year, the Federal share to be $10,978 and the local share $3,660, an amount already pledged by the board of directors of the community center. Shortly thereafter the center's board of directors received word of an award of $14,000 from the Association for Crippled Children, New York, for the Desire Community School for Exceptional Children. This made it possible to meet the HEW matching requirement without depleting the meager funds of the Desire Community Center. There was now a total of $24,978 for operating the Desire Community School for Exceptional Children for a year, with options for renewal in the next year.

The director of the Desire Community Center was designated director of the school. In preparing for its opening, he worked closely with the Tulane field instructors and sought consultation from the administrators of other community services in New Orleans.

The parents' group met regularly during June, July, and August with the director or a Tulane field instructor, or both. The group leaders kept the parents informed of the progress in planning for the school, solicited their ideas, and kept alive the group's interest in the school's development.

The director, the attorney for the community center's board of directors, the Tulane field instructors, and a social work student met as a temporary planning committee. This committee projected tentative plans for the immediate future. The school would be physically located in the Desire Community Center, with tables, chairs, utilities, and janitorial services provided without cost by the center as a part of the contribution from the neighborhood. The next step was to enlarge the committee to include two representatives from the parents' group to be elected by the members, one person from the Desire Neighborhood Council on Health, Education, and Welfare, and another from the Desire Area Community Council. Known as the advisory council to the Desire Community School, the enlarged committee accepted responsibility for formulating policies to guide in the overall operation of the school and in hiring the school's staff—teacher-director, teacher aide, and secretary.

In August the advisory council selected two teachers from a roster of 12 applicants. One, a woman qualified by training and experience, was designated teacher-director. Her duties would be both to work with the children and to share administrative responsibilities with the director. The other, a man, was chosen not only because of his academic training but also because of the prevalence of boys in the potential school population. The secretary of the center was made the school's part-time secretary.

Desire Community School for Exceptional Children opened on September 5, 1969, with six students and two teachers. By May 1970 the student population had increased to 25.

The Tulane students assigned to the Desire area carry intake responsibilities for the school. The school's secretary refers all applicants for admission to them. When a student receives a referral, he visits the family for an interview and counsels the parents in preparing the retarded child for attendance and for the psychological, physical, and,in some instances psychiatric examinations he will undergo. The student also provides continuing casework service to the family on the basis of individual need.

One of Tulane's field instructors meets weekly with the two teachers to help with curriculum planning and with problems arising from the newness of the service.

The regular meetings of the parents' group, the school's advisory council, and the board of directors of the Desire Community Center keep members of the community involved in the project. Under continuing discussion are such issues as the relationship of the school to the New Orleans public school system and the meaning and place of the community school in the neighborhood.

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reaching for the dream: AN EXPERIMENT IN TWO-WAY BUSING

NORMAN N. GROSS

have a dream that my little children will one day live n a nation where they will not be judged by the color of their skin, but by the content of their character.—Martin Luther King, Jr., at the March on Washington, August 28, 1963.

One of the greatest obstacles to realization of Dr. King's dream is de facto segregation in the schools of our metropolitan areas. As long as white children and black children do not have an opportunity to meet naturally in the course of their day-to-day lives, they run the risk of growing up to see each other as racial stereotypes rather than as people.

Dr. King's dream is becoming a reality, however, n some parts of Rochester, N.Y., most particularly at the Clara Barton School. Each morning during the past school year in this innercity public school, 240 white children from all parts of the city began the day with about 1,300 black children. Before the program to bring the white children to Clara Barton was started, the school was nearly 98 percent black. Today the white percentage would be even greater than its present 16 percent if the many white children on the waiting list could be accommodated. Families from all over the city are asking to send their children to Clara Barton for one or both of two reasons: (1) the school is known for its record of high academic achievement, and (2) the parents wish to have their children participate in a racially integrated educational experience.

Busing schoolchildren is a two-way proposition in Rochester and is carried out entirely on a voluntary basis. It began in 1963 in the more common one-way direction. At that time in response to pressure from parents, the New York Board of Regents, and the U.S. Civil Rights Commission for the city to end de facto segregation in the schools, the local school board adopted an open enrollment policy. To encourage transfers the superintendent of schools sent letters to the parents of children in the seven predominantly black innercity schools, offering to transport their children to schools on the city's outer rim. The board received 1,500 requests from the parents of children in six innercity elementary schools for the 513 places open in the 18 outercity elementary receiving schools. Of the 513 children selected, 495 completed the school year in the schools to which they had been assigned. Of these 480 returned the following year along with 195 new transfers. In the fall of 1969 these 18 schools in the city's white rim increased to 23 schools containing 1,237 children from the inner city. In addition, there were some 321 youngsters from one innercity secondary school traveling to three outercity secondary schools.

The success of this experiment led some suburban school districts where the schools had few if any blacks to open their facilities to children from the inner city with the announced purpose of overcoming the isolation of the white children. The first to do so was the school system of West Irondequoit. This school system has been taking in 25 first graders from

Children arriving from an outer residential area to the Clara Barton Elementary School in Rochester's inner city.

the inner city each year since 1965, with the goal of eventually having about 300 innercity children in the school system at one time. Before the program began, West Irondequoit had only four black children in its school system's total enrollment of 5,800. During 1969–70 it had 87.

Four other suburbs eventually followed West Irondequoit's lead. The city provides transportation and pays tuition for the innercity children who attend these suburban schools.

Busing in reverse

Busing in reverse—from outer- to inner-city areas—however, did not begin until the fall of 1967.

In following the school board's direction for a voluntary enrollment policy, the superintendent of schools had announced that two of the newer innercity elementary schools were also open to pupils from any part of the city and that transportation would be provided for children who lived outside the school's normal boundaries. One was the new Public School Number 2, the Clara Barton School, and the other Public School Number 6, which covers only kindergarten through the second grade. When there was no response to this offer, some members of the black community who had been working for greater school desegregation began to express resentment that the black children had to do all the moving.

Many people in Rochester said that white parents—even those who had been clamoring for desegregation—would not send their children to a predominantly black school in the inner city. At first they seemed to be right. Early in 1967 the superintendent's office sent out 28,000 brochures to parents of elementary school children in the white outer rim of the city, urging them to send their children to the "beautiful new Number 2 School." Only four responses pledging unqualified support of this policy were received from this mailing.

The superintendent did not give up. Armed with slides and a well-prepared statement of the educational advantages of a racially integrated school experience, he and members of his staff met with groups of white parents. Parents who showed interest were asked to gather others. Coffee hours to discuss the plan were held in homes in all the white areas of the city. Applications from white parents for transfer of their children to the Clara Barton School began pouring in to the superintendent's office.

This courting of white parents, however, almost proved to be a disastrous mistake. Black parents who lived in the school's neighborhood expressed resentment at not being accorded similar attention. After all, they pointed out, if white children were to be admitted to the Clara Barton School, some black parents would have to volunteer to send their children elsewhere. Since these criticisms were valid, the superintendent and his staff began enlisting the support of the black community for making the Clara Barton program a success.

In September 1967, 140 white children from 30 schools in the outer parts of the city began attending the Clara Barton School in the heart of the city. Among them were the children of doctors, lawyers, and prominent community leaders, including the city manager.

Parent involvement was a crucial factor in the success of the program. The Clara Barton School had a black parents' organization, unaffiliated with the traditional PTA. White parents who attended their meetings soon discovered that there was no lack of black neighborhood leadership. After several months of cautious testing by black parents and white parents alike, a truly integrated parents' group emerged. Apparently judging each other "not by the color of skin, but by the content of character," black parents and white parents worked together to bring improvements to the school. Among their achievements was a successful demand that officials provide the school with a hot lunch program.

There were numerous irritations during the first ar. Buses would arrive late and leave late. Teach- es and parents had to supervise the bused-in chil- ren at lunch time. Led by a deeply committed prin- pal, the school's staff accepted the difficulties with ace. The teachers seemed to respond to the new mix pupils in their classes with a revitalized interest i teaching.

The untimely death of Martin Luther King, Jr., sulted in an even more vigorous effort to expand is reverse open enrollment program. The Com- ittee for Expanded School Integration, a racially tegrated group of parents and teachers from the lara Barton School, gave this renewed effort ener- tic support. This time the appeal for voluntary en- llment of children in other than their neighborhood hools was made to black parents and white parents ike.

The new Virgil I. Grissom School, Public School umber 7, in the city's white rim, was paired with e Clara Barton School for a voluntary exchange of upils. Both schools received some of the same en- chment programs, such as special instruction in athematics and science, remedial reading, a French rogram, and a Far Eastern Studies program. In ddition, Project Beacon, a black studies program de- gned to develop self-esteem in black youngsters, was ffered to all children at the Clara Barton School. t was found that white children were as interested s black children in this program.

To make certain the message reached the parents, he children of each school carried home a brochure hat their fathers could assemble into a model Saturn ocket. Most of the brochures reached home. The re- ponses were encouraging. Informational meetings ere held in various places in the city, including pri- ate homes. This time experienced parents, both lack and white, their children, and teachers from he Clara Barton School fielded the questions from ther parents of both races.

Some 192 white children from all parts of Roches- er attended the Clara Barton School in 1968–69. In 969–70 the white enrollment had increased to 240, ith a waiting list of 170 white children.

Today campaigns are no longer needed to recruit hite children for the Clara Barton School. In fact, everal white families have moved into Rochester n an effort to have their children admitted there. ther suburban parents have also sought to have their hildren admitted to the school, with no success. ome white parents have asked to have space reserved t the school for their preschool children. In addition, he formerly all black Number 6 School, which has not received the same kind of concentrated attention, now has 24 white pupils enrolled.

The lack of available space has become the major obstacle to further integration of the Clara Barton School. The school has such a reputation for achievement and such esprit de corps among parents, teachers, and children that neighborhood parents are reluctant to transfer their children elsewhere, even though they are assured of an equally good school. Consequently only 19 of the school's 38 classes are integrated. To spread the 16 percent of the white children throughout the school would result in a truly integrated experience for nobody.

Academic achievement

More than 3,000 pupils have been involved in Rochester's open enrollment program. In the beginning there were dire predictions from some quarters that the presence of the innercity children in classes with white children would slow up the academic program and result in lessening the white children's achievement. Such has not been the case. In fact, in some instances the results have been the opposite—the mixed classes seem to have been a spur to achievement to white children and black children alike. Studies of children's achievement records show, for example, that—

- In the West Irondequoit school the white chil-

Children from Rochester's outer rim and from its inner core attend class together at the Clara Barton School.

dren in the integrated classes are doing better than the white children in the nonintegrated classes. The black children in that school are doing as well as or better than the children in the same grades at the schools from which they transferred.

- In the Clara Barton School the achievement record of the entire school has risen since the white children have come in. The black children in the integrated classes are doing about the same as the black children in the nonintegrated classes, but the achievement of the black children in both types of classes has risen. The white children are doing as well as the white children in the schools from which they transferred.

- In the Rochester area as a whole the black children who transferred to predominantly white schools are doing as well as or better than they were in their former schools, and the white children in the integrated classes are doing as well as they were before.

The future

True racial integration in the schools is still a distant goal in Rochester. In spite of the auspicious beginning, most of the children in the public schools still see only members of their own race in their classes. Moreover, each movement made toward desegregation has met with some resistance from segments of the local community.

New moves toward further integration are to be made in the fall of 1970. A new program will put less emphasis on busing, on the theory that—all else being equal—it is more desirable for children to go to schools near their homes. The two-way transfer program will, however, be continued.

Under the new program two school zones will be expanded to include both predominantly black and predominantly white neighborhoods. Each of the neighborhood schools in these zones will be reorganized to include only specific grades. For example, in one zone, which contains three elementary schools, two schools will include only kindergarten through the third grade, while the other school will serve the fourth through the sixth grades. Since each school will draw its enrollment from throughout the zone, each school will be integrated. Yet most of the children who attend them will live near enough to walk to school.

This plan, too, will meet with some resistance. But, like the two-way busing program, it stems from a resolution adopted by the Rochester School Board in 1963. In this resolution the Board expressed the belief that "the function of the schools is to prepare children for life in a democratic society" and that "the fulfillment of this function depends in part on the degree to which children have opportunities during their public school careers to become acquainted with children from a variety of cultures."

The experience of the two-way transfer program suggests that such opportunities help children to academic achievement. They may also lead to the fulfillment of Dr. King's dream.

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> Let me tell you that the racial revolution in this country has helped white children more than they will ever know, because of what it has done educationally, apart from the desegregation of the schools. The whole racial revolution has made us focus on the general problems of education. It has made us more aware, more critical, and more responsible.
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> *Robert Coles, "Communication: The Essential Bridge," In* The Function of Rebellion—Is Youth Creating New Family Values? *Child Study Association of America, New York, N.Y. 1969.*

A CLINIC FOR CHILDREN WITH LEARNING DISABILITIES

MURRAY M. KAPPELMAN
ROBERT L. GANTER

In recent years pediatric clinics have noted what appears to be an alarming increase in the number of children seriously handicapped in their ability to learn. The "increase" may be real, but more likely it is a reflection of the growing sensitivity within the medical and education professions to the importance of identifying such children early and referring them to diagnostic and remedial services so that pathways to learning can be found for them.

In most hospitals, the outpatient pediatric clinic bears the primary responsibility for the diagnosis and followup of the complex problems such children present. However, the average pediatric clinic is too overburdened with the health supervision of children, sick and well, to be able to take time for the detailed history-taking and examination necessary for achieving a full understanding of the medical aspects of a child's learning problems and to correlate these findings with the results of psychological, psychiatric, and social work consultations and visual, speech, and auditory investigations. Yet this is the type of comprehensive, coordinated service without which many children with remediable learning problems are destined for educational oblivion.

To prevent such intellectual waste Sinai Hospital of Baltimore opened a multidisciplinary learning disability clinic in September 1967. The clinic is designed not only to identify the child's specific learning problem, but also to provide guidance and followup in getting the child the specific kind of educational program that can help him learn.

Specific disabilities

The children seen at the Learning Disability Clinic nearly all have one or more specific learning disabilities—identifiable conditions that prevent the adequate accumulation, retention, and utilization of knowledge. For the most part these children fall into the following categories:

The hyperkinetic (overactive) minimally brain injured child. Such a child has poor impulse control and is therefore often overtly disruptive in class. He has a short attention span and poor memory retention and is highly distractible. His symptoms are derived from some degree of central nervous system dysfunction that stems from irreversible brain injury. Careful psychometric testing may indicate that the child has an adequate or superior intellectual potential, but such testing does not always detect the child's inability to utilize the materials that are part of the usual learning situation.

With the aid of certain drugs, selective educational placement, and continuous counseling of his parents and teacher, such a child may be helped to learn. The failure to provide this kind of program all too often leads to a poorly educated, emotionally damaged adolescent who is totally unprepared to face the social and economic world around him.

The autistic minimally brain injured child. Such a child also has a central nervous system dysfunction, but is withdrawn, uncommunicative and pathologically shy. Failing to respond to a learning situation, he presents a superficial picture of mental retardation and consequently may mistakenly be regarded as dull in all intellectual areas. Psychological and psychiatric tests may reveal a strong element of depression. Attempts to help such a child through intensive psychiatric treatment without an understanding of the underlying pathology may prove futile. Remediation of the child's learning problem calls for appropriate educational placement and the application of new methods of behavior modification, individualized counseling, and tutoring.

The child with perceptual dysfunctions. The child with disorganization in perceptual areas, stemming from an impairment of the central nervous system, may be affected in any of three ways: he may be unable to learn to read, to conceptualize or reason, or to convert visual impressions into meaningful information. None of these perceptual difficulties is likely to be noticed until the child has been in school long enough for it to show up as a handicap. Diagnosis of the specific type of perceptual difficulty is extremely important as a basis for planning an effective educational program for the child.

In 1958 Kawi and Pasamaneck in a study of 410 children compared the prenatal histories of those with and those without reading problems; they found that before or during birth 16.6 percent of the children with reading problems, but only 1.5 percent of those without reading problems, had been exposed to four or more complications in their mother's pregnancy or delivery.[1] Such findings suggest that many of the children with reading problems may have suffered some brain injury before or during birth, resulting in dyslexia—an organically based inability to read.

In some children, most of them boys, reading problems seem to stem from a familial developmental idiosyncracy rather than from a true organic perceptual dysfunction. In these children the visual-motor function necessary for reading develops more slowly than other types of perceptual functioning. While this handicap improves with time, it impedes the child's ability to learn during his most formative years.

Some children, however, seem to have a permanent organically based impairment in visual-motor coordination that blocks their ability to convert visual images into meaningful information.[2] Such children can learn, but only with the application of special teaching techniques.

Special techniques are also required for helping the child who has an organically based inability to conceptualize or use facts he has already learned. The child's difficulties may not become apparent until he is faced with increasingly complex arithmetic problems or subjects requiring the use of memory.

The child with a central communication disorder. Such a child is unable to express verbally or in writing what he knows to be an accurate response.[3] Often children with this type of disorder become so frustrated they discontinue any attempts to respond to the teacher's demands. Their problem is related to an interruption of impulse transmission in the central nervous system. Remediation calls for intelligent cooperation between physician, educator, speech therapist, tutor, parent, and child.

All learning difficulties, of course, are not caused by the specific problems just described. Some children have their ability to learn hampered by severe emotional problems, some by lack of motivation (which may have been snuffed out by conditions in the school itself), others by immature or uneven development, and still others by a low intellectual potential. Such problems have to be considered and ruled out in attempts to diagnose the specific difficulty.

The clinic and its team

Sinai Hospital lies in an area that has been experiencing a rapidly decreasing socioeconomic level and increasing child population. The Learning Disability Clinic was established when it became apparent that neither the diagnostic facilities of the school system's special education division nor the hospital's outpatient pediatric clinic could meet the overwhelming number of requests for evaluation of children referred from the schools because of problems in behavior or achievement. Its focus has been largely on children referred from a large elementary school with an enrollment of 1,400 children, most of whom are from disadvantaged families, although it also serves children from other elementary schools.

The design of the Learning Disability Clinic has been influenced by a study of children with serious learning problems made in another section of the city by the authors of this article, in which over half the children studied were found to have an organic basis for their difficulties.[4] This study demonstrated that a successful mechanism for identifying the source of a child's learning problems is a multidisciplinary "school health team."

The school health team at the Learning Disability Clinic includes the child's teacher and school principal as well as hospital staff members of a variety of disciplines: a pediatrician, a clinical psychologist, a psychiatric social worker, a social work assistant, a peech and hearing specialist, a psychometrician, and n experimental psychologist. In addition, an educaional consultant from the school system's special ducation division provides liaison between the clinic and the school.

The assessment. In participating in the initial diagnostic process, each team member has a specific funcion to perform and must blend his activities into the omposite assessment of the child as a whole.

The pediatrician takes a detailed medical history of the child and gives him a thorough physical examnation, including a neurologic examination geared to uncover subtle as well as gross abnormalities. He also serves as chairman of the team conferences held to integrate each staff member's findings on the child and to determine a course of remedial action.

The clinical psychologist monitors and interprets all testing done on the patient. He also interviews the child and his parents for detection of significant emotional problems.

The psychiatric social worker interviews the parents in an effort to assemble a portrait of the total environment of the child and his family. The social worker's interviews are often carried out in the child's home where situational handicaps are more likely to be detected.

The speech and hearing specialist tests the child's hearing and his articulation in speaking and analyzes his use of language for degree of development and discrimination to detect any distortions or deletions that might provide clues to the nature of his learning problem.

The psychometrician administers such tests as the Wechsler Intelligence Scale for Children (WISC) and the Bender-Gestalt recall test and figure drawings (for memory span and accuracy of perceptions) and observes the child in school to see how the test results relate to the child's performance.

The social work assistant spends most of her time in the school observing children who are being considered for referral to select those with the most immediate and severe problems for the clinic's attention so that they may receive treatment before irreparable harm to their learning has taken place.

The educational consultant outlines the resources within the field of education appropriate for the child under study.

Followup. The Learning Disability Clinic is designed not only to assess a child's problem and potentialities but also to guide followup action to meet the child's emotional and educational needs. Here again each member of the health team plays a part.

The pediatrician schedules regular return visits with children who are placed on medication. These are most often the hyperkinetic children.

The pediatrician and the clinical psychologist regularly counsel the child and his family in relation to adjustments needed in the child's educational arrangement and in other areas of his environment.

The social worker and social work assistant maintain a continuous relationship with those families in need of reestablishing a stable home environment. In addition, the social work assistant, under the supervision of the social worker and the psychologist, conducts group sessions with parents of children with similar learning disabilities.

The speech and hearing specialist conducts speech therapy sessions for children who are unable to receive such therapy within the school. She also follows the progress of those children who are receiving speech therapy in the school or elsewhere outside the Learning Disability Clinic.

The experimental psychologist helps the school staff understand and apply methods of modifying children's behavior in the daily school environment.

The educational consultant interprets the clinic's technical diagnosis and recommendations to the teachers at the school, helping them to see how the child's educational needs fit into the teacher's daily responsibilities. In addition to advising on an education program to meet the child's individual needs and deficiencies, she may suggest major changes needed by the school as a whole and even by the entire educational system.

Steps in operation

The first step in getting a child into the Learning Disability Clinic is for the child's teacher to recognize that he had a learning problem. The social work assistant has helped teachers learn to recognize such children by conducting group sessions in which she explained the medical and psychological basis of the various types of learning problems, the mode of their presentation, and the classroom manifestations of these disorders.

When a teacher suspects that a child has such a disorder, she informs the principal, who schedules a conference with the teacher and social work assistant to discuss the child's behavior and decide whether a referral to the clinic should be made. If the decision is for referral, the social work assistant collects all the health data available on the child in the school,

Murray M. Kappelman, M.D., (left) and **Robert L. Ganter, Ph. D.,** report here on their work at Sinai Hospital, Baltimore, Md., where Dr. Kappelman is the associate pediatrician-in-chief and a coordinator of the Learning Disability Clinic and Dr. Ganter is senior clinical psychologist. Dr. Kappelman also teaches in the pediatrics departments of Johns Hopkins University and the University of Maryland schools of medicine; Dr. Ganter is engaged in the private practice of clinical psychology.

including the results of eye tests, and transmits this material to the clinic along with a concise report of her own observations of the child's behavior in the classroom.

In the next step the clinic's social worker or the school principal contact one or both of the child's parents, to inform them of the importance of the scheduled evaluation of the child. Then the social worker interviews the parents in the home if possible and the psychometrician tests the child either at school or at the clinic.

When the child first visits the clinic, the parents and child are interviewed separately by the pediatrician and psychologist. Then the child is given his physical examination and the speech and hearing evaluation and the parents are interviewed individually by the psychologist. When indicated, neurologic, ophthalmologic, or psychiatric consultations are requested from the appropriate department of the hospital and any special laboratory work indicated is scheduled. The existence of a specific learning disability is not assumed until ill health, malnutrition, hearing loss, or visual impairment or imbalance have been ruled out as the underlying cause of the child's poor school performance.

When the results of all these tests have been assembled, the team holds a conference on the child. At this conference, all of the team members involved are present to discuss their findings. The school principal and the child's teacher are also present to describe the child's behavior in school and report on whatever resources the school is already using in behalf of the child. The findings of the clinical investigations are discussed by the team as a whole and a presumptive diagnosis of the child's primary problem is made. The educational consultant then proposes teaching techniques in line with the clinical findings on the child. At this point a practical treatment plan is formulated, and a decision is made about who among the team members will serve as the primary continuing counselors for the parents and the child.

Every 3 months the team conferences are devoted to an analysis of the problems of each child previously evaluated and of the progress he has made in relation to whether changes in treatment are indicated. This recurrent review by the clinical team and educational personnel prevents subtle changes and new problems from being overlooked in the continuous intellectual, social, and educational growth of the child.

The following case summaries illustrate how this kind of coordinated effort works.

A hyperkinetic child

Duane, the first child involved in the Learning Disability Clinic, was referred from the school at age 6 because of his extreme excitability, distractibility, impulsiveness, and inability to concentrate and remain still. He had been in the first grade for 3 days. The year before he had entered kindergarten but had been withdrawn on the advice of the school because of "immaturity and inability to get along."

There was nothing in Duane's birth or perinatal history to suggest that he had been anything but a healthy baby. However, his mother said he had not spoken at all until he was more than 3 years old, when he had suddenly begun speaking in sentences.

The mother reported that Duane's social behavior had seemed similar to that of her other children until he was nearly 3 years old, when he became very difficult to handle. His behavior was now so erratic that other children did not want to play with him and his father was reluctant to take him along on outings because of his severe hyperactivity and impulsivity. The parents could not recall that the child had ever suffered any serious accidents or injuries.

Duane's physical examination revealed normal gross development. The only deviations revealed in his neurological examination were dsydiadochokinesis (inability to perform alternating movements rapidly), minimal mirror movements (movements made on the opposite side from that intended), and slightly awkward gross movements. However, there were no other gross or subtle signs of neurological difficulties.

The speech and language evaluation indicated that Duane was well below normal for his age in language development and vocabulary. However, he was near normal for his age in coordination of auditory skill with visual identification, and in auditory sequential skills (as revealed in his ability to repeat a series of numbers when asked).

In the psychological evaluations, Duane scored a year above his chronological age in social maturity, but he showed a short ttention span, extreme perseveration, severe perceptual dysfunctioning, and evidence of perceptual dysfunctioning. These results strongly pointed in the direction of organic brain damage. Medication was recommended, and in November 1967 Duane was placed on dexedrine—a drug that stimulates adults but tranquilizes hyperkinetic children.

The social worker interviewed Duane's mother several times in an effort to help the parents adjust to the child's severe hyperactivity, understand that Duane could not control his hyperactivity, and curb their tendency to reject him. The parents gradually became more appreciative of Duane's problems and learned to deal with his behavior more realistically.

In May 1968 the vice principal of Duane's school wrote the following note in the boy's chart:

"In September 1967 this pupil was unable to remain in a classroom beyond a period of about 2 hours. His conduct consisted of extreme activity, inability to concentrate and remain still, distractibility, belligerence and impulsiveness. May I report that I have now heard Duane read successfully from a first reader showing an understanding of what he read. For the most part of the day this boy can now maintain himself in the classroom and he is making some scholastic progress. We did not think last September that Duane would have reached this point in such a relatively short period of time."

Duane continued to take dexedrine until December 1969, when his mother spontaneously discontinued it. When the social worker saw her in January 1970, she said that even without medication Duane was no longer hyperactive; he was performing better in school, he could concentrate longer, and his memory had improved.

Duane's report cards are now satisfactory—far better than his original WISC test seemed to indicate was possible. He can concentrate longer. The period of medication combined with a permanently improved home situation obviously have increased this child's ability to control his behavior and to learn.

A perceptual handicap

The second illustration involves a child found to have a visual-motor perceptual handicap.

Carla, age 6 years and 7 months, was presented to the Learning Disability Clinic with her mother on May 16, 1969, because of an inability to copy material from the blackboard, poor handwriting, and failure to achieve in school.

The prenatal history revealed that Carla's mother had taken medication for high blood pressure during her pregnancy with Carla. However, her delivery and the child's birth weight were normal. The child's perinatal history was satisfactory as was the ensuing developmental history except that she had not yet learned to tie her shoes. Her mother said that Carla was sometimes clumsy and fell down a great deal but gave no other evidence of incoordination of gross movements. She said that Carla concentrated well but had never attempted to color in a coloring book. She reported that Carla was not overactive nor perseverative.

Carla's physical examination revealed no gross abnormalities. A neurological examination showed that the child had an extremely bizarre dysdiadochokinesis for her age, mild mirror movements, slight tremor when her hands were in an outstretched position, and moderate trouble in walking a straight line. She swayed slightly when standing with feet close together and eyes closed, but not enough to give a neurological clue.

Carla's speech and hearing tested as essentially normal. Social service investigation revealed that she lived in a well-adjusted family.

Carla's mother told of the child's fantasy life, which seemed to be somewhat excessive for her age. The clinical team regarded this as symptomatic of a lowered self-esteem caused by her learning difficulties.

In the psychological evaluation Carla scored in the average range on the WISC test. On other tests, however, she showed erratic verbal functioning and extreme perceptual dysfunctioning, especially revealed in body distortion in her drawings. She found the Bender-Gestalt test very difficult and began to tear up the paper after trying the section testing recall. While attempting to copy something on paper she used excessive hand motion and failed to separate words. She spent a great deal of effort in her writing but the result was chaotic. However, ophthalmologic evaluation indicated that she had normal vision.

The ultimate diagnosis was that Carla had a serious problem in visual-motor coordination resulting in an impaired transmission of impulse from eye to hand. The social work assistant explained the nature of Carla's handicap to the child's teacher. As a result, the teacher began allowing Carla to work at her own pace and use large writing materials.

The educational consultant began seeing Carla regularly to analyze her school performance and develop procedures that could be helpful in improving it. She then sat down with the child's teacher to give her a more definite picture of the methods that might help Carla and has been following through with continuing advice.

The social worker initiated a series of interviews with the mother in an effort to increase the family's understanding of the child's real potential and ways of helping the child to improve her own image of her abilities.

Carla has begun to function better both in the school and in the home. Her writing is less sloppy than it was and she can now complete blackboard assignments. Here again, teamwork in diagnosis and followup has put a handicapped child on the road to a successful learning experience.

Goals and policies

From its beginning Sinai's Learning Disabilty Clinic has had five goals:

1. To provide as complete an assessment of the child with serious learning problems as possible

through the coordinated use of resources available within the hospital.

As we have tried to show here, the team approach not only eliminates delays in the diagnosis, but enhances the possibility of an accurate diagnosis by permitting a comprehensive review of the child's problems in a conference of all the professional persons involved. To guarantee meticulous attention to each child during both diagnosis and treatment, the clinic keeps a control on its intake and initiates case-finding efforts only when the prospect of intervention is imminent. It maintains an active caseload of 150 children, but because many children respond to short-term treatment, it can take on about 100 to 200 new cases each year.

2. To maintain continuing contact with the child from various vantage points in order to observe his progress and development, and so maintain flexibility in treatment.

Such continuing supervision, based on recognition that children and the circumstances around them are constantly changing, allows for indicated changes in medication and extended individual or group counseling of parent, child, and teacher.

3. To provide a medium for training professional persons from the hospital, the school, and community services on the nature of learning disabilities and the needs of children afflicted with them.

The hospital's pediatric residents all spend time working in the clinic, on a rotating basis, as do many student nurses and mental health counselors in training. New teachers at the school are invited to observe the clinic's case conferences.

4. To alert the community to the signs of future school problems in young children, since the earlier a child receives assistance for his learning problem, the better will be the result—whether the problem is one of inadequate stimulation, emotional instability or immaturity, or organic abnormalities.

Clinic staff members are carrying out an educational program involving lectures, seminars, publications, and news releases aimed at parents and teachers of preschools as well as elementary schools, public health personnel, physicians in private practice, and the general public.

5. To explore the vast uncharted terrain in the etiology and remediation of learning disabilities—now largely a field of conjecture.

The clinic is conducting studies of the prenatal histories of the children diagnosed as having specific learning disabilities to identify the relationship of specific prenatal factors to each type of disability; the effects of methods of behavior modification on the learning ability of the hyperactive, brain injured child; and the effects of specific types of drugs on specific disabilities. Among research the clinic hopes to conduct in the future are studies of the perinatal and early childhood periods of children with various types of learning disabilities as compared with similar periods in a problem-free control group, in an effort to elucidate factors contributing to each type of disability, including the importance of nutritional, social, emotional, and educational deficiencies.

The results of such studies could, for the first time, put prevention of learning disabilities within the realm of possibility.

Today our growing population contains a vast number of maladjusted young people whose attitudes toward themselves and the world in general might be traced back to serious learning problems. The feelings of frustration and inadequacy that result from failure to achieve in school too often destroy a young person's aspirations and self-esteem and so lead to antisocial behavior. Comprehensive diagnostic and treatment programs for children with learning problems have not been in existence long enough or on an extensive enough basis to tell whether they hold promise as an effective social instrument for preventing widespread maladjustment in young people. Sinai's Learning Disability Clinic however, in the few years it has existed, has demonstrated that skilled multidisciplinary attention can lead individual children with specific learning disabilities out of an intellectual and emotional morass to clear pathways of achievement.

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a DIFFERENTIAL USE of GROUP HOMES for DELINQUENT BOYS

JOHN W. PEARSON

In recent years there has been a nationwide emphasis on the treatment of juvenile delinquents in their home communities.[1, 2] Along with this emphasis has come an increasing use of group homes. On the theory that different types of boys need different types of homes, the California State Youth Authority, under a grant from the National Institute of Mental Health, has carried out a 3-year study of the differential use of group homes for teenage delinquent boys, called the Group Home Project: Differential Treatment Environments for Delinquents (MH 14979). This study was conducted between April 1966 and October 1969 as an integral part of the Community Treatment Project, a comprehensive research and demonstration project jointly sponsored by the Youth Authority and NIMH.[3]

The concept of group homes is not new; such homes were first used in New York City in 1916.[4] Group homes vary in definition, staffing patterns, and use. Some are owned and professionally staffed by agencies and provide complete care and casework services to children in residence; others are basically foster homes in which a family offers care and supervision within its own life style to several foster children. The Group Home Project has been an attempt to gain a more complete understanding of one pattern of use of group homes for delinquents.

The project produced a mixture of experiences that raised as many questions as it answered. While the staff remains convinced that group homes are frequently preferable to foster homes for delinquents, the experience in the project has indicated that the use of group homes as the only method of treatment offers no panacea for the rehabilitation of delinquent teenagers.

The Community Treatment Project, of which the Group Home Project was a part, was designed to compare the effectiveness of an intensive treatment and control program in the community with the Youth Authority's traditional programs of institutionalization and parole under the supervision of parole officers who carried an average of 70 to 80 active cases. The first two phases, carried on from late 1961 to October 1969, involved boys and girls 13 to 18 years of age committed for the first time to the Youth Authority by juvenile courts in metropolitan areas of Stockton, Sacramento, and San Francisco.

The subjects were randomly assigned either to the Community Treatment Project for treatment in the community by a parole agent carrying an average caseload of 12, or to a State training school as a control. Because smaller caseloads have not themselves guaranteed adequate treatment,[5] other dimensions were incorporated. These included:

1. Classification of the young people according to their level of maturity under the Interpersonal Maturity Level Classification for Juveniles, or the I-level system.[6] (See box, p. 145.)

2. Matching of the delinquent and parole agent according to the delinquent's personality traits and needs and the agent's personality, style, and preference in dealing with young people.

3. Planning an individualized treatment program for each young person, based on his unique needs, his personality, and on short- and long-range goals.

4. Using the relationship between the young person and the agent as the major vehicle for change.

The parole agent's role has been to work closely with each youngster assigned to him, providing individual, family, or group and casework treatment services and using available resources for care—including out-of-home placement, training, counseling, education, and recreation. The effectiveness of the Community Treatment Project has been demonstrated by lower recidivism, greater changes toward more positive attitudes, and a greater proportion of successful discharges from parole among the youngsters in the community-based treatment than among those in the control group.[7]

Parole agents in this project realized that many young delinquents need living situations that would *permit* nondelinquent behavior and that would enhance—or at least not actively interfere with—the treatment program. For example, a young person who relates to his world through conformity, or "allegiance" to friends who put pressure on him, may have little or no alternative to becoming delinquent if he lives in a neighborhood of high delinquency. Another youngster may escape neurotic conflict within his family through delinquent acting out. The use of out-of-home placements by the Community Treatment Project staff was therefore markedly greater than the state average for all parole agents.

Problems arose in locating and maintaining suitable foster homes within the Community Treatment Project. Many parole agents saw the need for a more controlled atmosphere than available foster homes could provide. Temporary housing was often needed on an emergency basis. These circumstances suggested the need for different kinds of placement facilities for different purposes. Group homes were seen as one means of meeting these needs.

The idea of the Group Home Project began to take form as early as 1962 with a limited, largely nonsystematic use of group homes within the Community Treatment Project.[8] Adding impetus to the idea was the recommendation from a statewide study that the Youth Authority "immediately proceed to set up a significant number of agency-operated group homes . . . with the particular purpose of learning as much as possible about their operation. . . ."[9]

The group homes

The goals of the Group Home Project were: (a) to determine the feasibility of establishing and maintaining different types of group homes: (b) to develop a taxonomy of environments describing the important aspects of such environments in treatment-relevant ways: and (c) to evaluate the impact of the group home experience on the young people on parole. All these goals relate to the attempt to assess the relative worth of each home as a placement alternative and treatment resource and its implications for use in other settings.

Five types of group homes were defined in the original proposal in 1965, based on the concept of differential treatment.[10] A sixth type was added by the project staff in 1968. Types I, II, III, and VI were designed as long-term care homes to meet the different treatment and control needs of many youngsters in the three major I-level categories (I_2, I_3, and I_4). Home types IV and V were designed for short-term care of delinquent youngsters of all subtypes. Following are brief descriptions of the models.

Type I—Protective (for four boys classified as passive asocialized or immature conformist). This type of group home for very immature, dependent youngsters is intended to approximate normal family living as closely as possible. It is designed to be operated by a married couple with training and patience to offer intensive support and supervision for prolonged periods of time. (Because the number of boys classified as low-maturity subtypes in the Community Treatment Project was smaller than anticipated, the Type I home in the project was opened in September 1967 to compatible high-maturity youngsters in the anxious and acting-out subtypes. For the most part this arrangement worked satisfactorily.)

Type II—Containment (for six boys classified as manipulator or cultural conformist). This type of home represents concrete and realistic demands for conforming, productive behavior. Opportunity for growth is fostered through the formation of healthy relationships with adults within the context of authority and control.

Type III—Boarding (for six boys classified as acting-out and anxious neurotic, situational emotional reaction, or cultural identifier). This type of home is for more mature boys with relatively complex personalities who are in the early stages of emancipation from their own families, but who do not have enough strength to be on their own. The group home provides a base from which to work as the boys continue to deal with the resolution of internal conflicts, problems of independence, identity, and the like. The group home parents maintain an atmosphere of comfort without threat, allowing the boys to form meaningful relationships with them if the boys so choose.

Type IV—Temporary Community Care (for six boys of any subtype). This type of home meets the need for temporary placement when custody or independent living is inappropriate or unnecessary. Support, rather than custody or restrictions, is emphasized. The home can be used for: (a) housing while another placement in the community is being changed or developed: (b) short-term counseling away from a stressful situation; and (c) housing while treatment plans are being formulated or reassessed.

Type V—Restriction (for six youngsters of any subtype). This type of home was conceived as a substitute for detention in juvenile facilities for boys needing fairly strict behavioral restrictions. (Because no suitable group parents were located, this type of home was not developed.)

Type VI—Individualized (for six youngsters of high-maturity subtypes, primarily neurotic acting-out and anxious). This type of home is designed for boys who may benefit from a familylike situation and healthy adult relationships while resolving conflicts within themselves and with their own families. A great deal of flexibility is allowed in regard to the purpose of placement and the nature of the relations the boys may develop with the group home parents.

The foster parents

The Group Home Project recruited its candidates for group home parents in much the same way that foster parents are usually recruited. The group home coordinator screened out unsuitable applicants, and the research worker conducted in-depth interviews with those remaining and administered two written questionnaires. The coordinator and research worker, first independently and then jointly, rated the candidates on 52 items relating to personality traits and behavior.[11]

In a team conference, parole agents, staff members of the Community Treatment Project, the coordinator, and the research worker evaluated information about the candidates to determine their: (a) appropriateness for foster care in general; (b) strongest areas of compatibility with specific subtypes of youngsters, home models, staff members, and current concepts of treatment; and (c) flexibility and potential for growth.

Under a contract with the Youth Authority, each couple selected to be group home parents provided a house with acceptable facilities and equipment in addition to care and maintenance of the youngsters placed in their homes. As reimbursement for their services and expenses, group home parents received a retainer at the beginning of each month, plus an additional fee for each boy who had been in the home during the preceding month. Monthly payments ranged from a $200 retainer plus $125 per boy to a $500 retainer plus $110 per boy, depending on the budget allocations for each type of home.

In all, seven sets of parents were employed to operate eight group homes: two each, protective, containment, and temporary care homes; one boarding and one individualized home. One couple operated a protective home and a temporary care home at different periods. At least 1 year's experience was obtained with each type of group home, except the restriction type.

Except in a few areas predetermined by the research design, attempts were made to handle issues and decisionmaking through a team approach. Thus, procedures for everyday operation and resolution of problems of training, management and continuation of the homes, staff meetings, evaluation, and termination of contracts were designed to involve everyone concerned—parole agents, supervisors, the coordinator, and research worker. Parole agents were primarily responsible for day-to-day communication, advice, and the like. Group home parents were involved in regularly scheduled meetings as frequently as possible to enhance their image as part of the team.

I-Level Classification

The Interpersonal Maturity Level Classification system, or I-level system, has been used as a tool in the Group Home Project and the Community Treatment Project for several purposes, including treatment and placement planning. This system distinguishes seven levels of maturity in interpersonal relations. The vast majority of juvenile delinquents have been found to fall within the middle three—I_2 (low), I_3 (middle), and I_4 (high). Within these three levels nine delinquent subtypes have been identified.[6] They are—

I-Level	Subtypes
I_2 (low)	Asocialized, aggressive Asocialized, passive
I_3 (middle)	Conformist, immature Conformist, cultural Manipulator
I_4 (high)	Neurotic, acting-out Neurotic, anxious Situational emotional reaction Cultural identifier

Boys placed in group homes remained with their original parole agents, so that existing or developing agent-boy relationships were not broken and agent-boy "matches" were not disturbed. In most homes this meant that more than one agent was working in the home at the same time.

For the most part group homes were allowed to operate within the natural life styles of the group home parents, with parole agents and the coordinator offering direction and advice. For example, some families set up formal written "rules of the home" for the youngsters; others did not. None of the homes developed time-structured schedules for activities except for meals.

Parole agents worked out with each boy the out-of-home activities that were required and those that were optional. Most boys attended classes, either in a public school or the parole center, or both, individual and group therapy, and organized recreation.

Placement in a group home was always a planned aspect of treatment, reflecting a basic tenet of the Community Treatment Project: individualized, rational, treatment-relevant decisionmaking. The use of group homes was considered *one* element of the program, not necessarily *the* major vehicle for treatment. A request for admission to a group home was made by the teenager's parole agent in conjunction with the agent's supervisor. If placement in a long-term care home was requested, the parole agent, supervisor, coordinator, and research worker met to determine whether the young person involved should be placed in a particular group home. In the temporary care homes, however, arrangements were made so that youngsters in need of emergency care could be placed at any hour of the night or day.

Placement in a group home could occur at the time of a boy's initial assignment to the Community Treatment Project or at any time during his period of parole. A decision about the length of stay in, or removal from, a home always took the boy's treatment needs into consideration.

Experiences and observations

Because of the nature of the project, its relation to the Community Treatment Project, and all the variables involved, it has been difficult to isolate the impact of group home placement on the boys. However, the project has contributed to a better understanding of many of the complex dimensions in the use of group homes in treating delinquents.

The discussion here is an overview of selected areas of the eight homes operated within the Group Home Project. More complete discussion is contained in the project's reports.[12-15] Final data analysis and reporting will be completed in the summer of 1970.

Overall, staff members regard the experiences of the Group Home Project positively, in spite of numerous problems. The homes frequently provided a much-needed service to youngsters. In the opinion of most parole agents, the group homes—although not meeting the "ideal" criteria for treating all young delinquents—offered many boys better living conditions and better treatment than any available alternative. Boys frequently were able to become stabilized, behaviorally as well as emotionally.

By June 30, 1969, a total of 39 boys representing 51 different placements had been placed in the long-term care group homes. (Some were placed in more than one home.) The average age at the time of each separate placement was 17 years, 2 months. The boys represented all I-level subtypes except for the asocialized subtypes of the I_2 or low level of maturity and the situational emotional reaction subtype of the I_4 or high level of maturity. The majority—57 percent—were classified either as the acting-out or anxious neurotic subtypes of the I_4 level. The boys had spent an average of 9.8 months on parole before group home placement and had been living either with their own parents, other relatives, or in foster homes. However, 49 percent of the group home placements were made within the first 6 months of parole. The average length of stay in all the long-term care group homes was 162 days (5.4 months).

Twenty-four boys representing 42 different placements were placed in the two temporary care homes. The average length of stay was 3.5 weeks, the average age at time of placement was 16 years, 9 months, and the average duration of parole before temporary care placement was 11 months. Most of the boys placed in these homes—72 percent—represented either the acting-out or anxious neurotic subtypes in the I-level classification.

Comparisons of scores of average expectancy of continued delinquent behavior[16] indicated that the group home boys, as a whole, tended to be worse parole risks than boys in the Community Treatment Project who were not placed in group homes.

Behavior ratings

Group home parents and parole agents made separate behavior ratings of boys in long-term care homes Types I, II, III, and VI, using the Youngster Behavior Inventory.[11] The parents' ratings reflected each boy's behavior in their home, whereas parole agents' ratings included the boy's behavior both within and away from the home. The first ratings were made after a boy had been in a home for 2 months, with further ratings at 2-month intervals.

Using the first ratings as a base for identifying behavioral change, group home parents perceived: (a) at 4 months the boys had made significant changes for the better in terms of an increase in positive, healthy behavior and decrease in negative, disturbed behavior; (b) at 6 months the indices of

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positive behavior were even more significant and indices of negative behavior had changed for the worse—but not significantly; (c) at 8 months the indices of positive behavior, although down from the 6-month rating, were still higher than the first ratings, but no longer significantly so, and negative behavior indices had significantly changed for the worse; (d) at 8 months for positive and negative indices combined, ratings in general reflected significant changes for the worse. This last finding is in marked contrast to the combined indices of significant change for the better at 4 months.

The parole agents' rating reflected a more consistently positive pattern of behavior, but none of the changes they observed reached statistical significance. Although the parole agents perceived changes for the worse at 6 months and 8 months on positive behavior indices, they perceived rather consistent changes for the better in 4-, 6-, and 8-month ratings on negative behavior indices, and on negative and positive indices combined.

The Group Home Project staff is presently investigating whether there are significant differences between different rating groups in terms of the background and other characteristics of the boys. Comparisons are also being made of the manner in which the breakdown occurred in group homes that were terminated. If this investigation does not account for the findings given here, it might be concluded that there appears to be a "point of diminishing return" in the value of group home placement, at least as perceived by the group home parents although not by the boys' parole agents.

Termination of homes

From November 1966 through June 1969, the period that data were collected for the project, the project's arrangements with four of the seven sets of group home parents were terminated—all by staff decision.

No single factor fully accounts for the termination of the project's use of four sets of group home parents. In a very general sense, staff members reached a point at which they felt that the couples' philosophies, personalities, and styles had fallen below minimum acceptable standards for meeting the needs of the boys or had not adapted to treatment changes.

In the first home terminated, the parents simply did not provide the level of care and supervision that the boys required. More complex factors were involved in the other three homes: they seemed to go through a similar sequence of events before culminating in termination. Their operations were, on the whole, encouraging and acceptable during early periods, only gradually and then more rapidly to go "downhill," both in regard to staff assessments and the parents' own feelings of competence.

With some exceptions, the boys provided relatively little positive feedback to the group home parents, either directly or in terms of noticeable, long-term change. The group home parents' reacted by complaining to—or opposing—parole agents while putting more pressure on the boys.

Once the parole agents began to sense that boys in a home were having detrimental experiences, they became dissatisfied with their efforts to alter the atmosphere in the home or became uncomfortable in dealing with the group home parents. Then their support for the group home parents usually dropped off and the home passed the "point of no return."

Most of the group home parents were blue collar workers with a high school education. They ranged from 25 to 74 years of age, with an average age of 43. Five couples had preschool age children or adolescents of their own living in their homes. Four couples—including two with whom group home arrangements were terminated—had had previous experience as foster parents.

Adding to the problems and frustrations was the fact that no effective system of relief time away from the boys was established for the group home parents, partly because of lack of funds and partly because of the couples' reluctance to let a "stranger" take care of their house.

In retrospect, it appears that different or more appropriate assistance could—and in some instances should—have been provided for the group home parents. The extent to which group home terminations and other problems might have been affected by such assistance has been the subject of much debate.

Overall, the longevity of the group homes seemed to be equal to, if not better than, most foster homes in the Community Treatment Project. The lack of a single request for termination from the group home parents contrasted with CTP's experience in having many such requests from foster parents.

Tentative conclusions

Among the tentative conclusions that may be drawn from the project's experiences are these:

1. Some couples who have provided satisfactory foster home care for individual children cannot handle the increased demands of caring for several seriously delinquent and frequently disturbed youngsters, particularly when they are expected by the treatment staff to fill complex roles.

2. Parole agents and group home parents, although selected to match the youngsters they serve, may not be a "good match" with one another.

3. To maintain or develop their natural strengths, group home parents require a substantial commitment of the staff's time and effort to provide them with support, information, and experiences relevant to where they are as people.

4. Group home parents who have an intuitive feel for, and acceptance of, the "adolescent turmoil" apart from delinquency, appear better able to weather crises with the boys and to "bounce back."

5. Relief is important for group home parents or live-in staff members; some spontaneously arranged time off is also desirable. Relief, as well as other assistance, should be flexible.

6. For some of the older, more seriously disturbed young people, group homes operated by the agency with salaried and professionally trained staff may provide better continuity of treatment and stability of atmosphere than any of the models tested. While this type of operation would be more expensive than the type described here and would sacrifice some "home" atmosphere, it could avoid much of the turmoil that arises from changes in physical placement when group homes are terminated.

In spite of the difficulties experienced, almost all parole agents and other staff members developed a general feeling that group homes should have a continuing role in the Community Treatment Project.

In view of the relatively high proportion of group home terminations and other problems, this attitude may seem paradoxical. But the group homes did tend to provide better, more predictable, and more readily available services than the foster homes used in the Community Treatment Project. The use of the temporary care home also prevented the institutional detention of many youngsters. Most boys were less resistant to placement in group homes, which they saw as part of the Community Treatment Project, than to placement alone with foster families.

Group homes thus offer a complex and sometimes difficult, but also important, variable in the treatment of delinquents. Only after careful planning in relation to the needs of the young people to be served and the goals of the agency and professional staff can the use of group homes bring maximum effectiveness.

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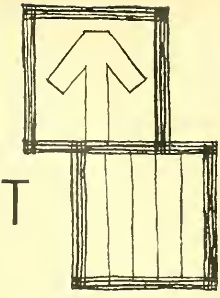

HEALTH CARE THROUGH HEAD START

GERTRUDE T. HUNTER

Project Head Start is a program for preschool children and their families, specifically those who are economically disadvantaged. Its long range goal is to help create, with the parents' participation, a system through which each child can attain and maintain optimum physical, emotional, and spiritual health and thereby contribute not only to his own well-being but to the well-being of society as a whole. With this broad objective, the Head Start program necessarily embodies many components, including in addition to its well-known educational aspects, health, nutritional, psychological, and social services. The effort is to make each of these services part of an integrated whole, in which they are interrelated in a way that will contribute to the total developmental experiences of children and their parents. An equally significant goal is to have a positive effect upon those individuals and institutions in the community who are responsible for providing services to children and their families.

Head Start programs have been conducted in large, medium, and small cities, suburban and rural communities, migrant camps, and Indian reservations. Since the beginning of Project Head Start in 1965, over 3.8 million children have been served in Head Start preschool centers in over 1,500 communities. Of these more than 1 million have attended year-round programs and more than 2.7 million, prekindergarten summer programs.

The Head Start health effort is based on the concept that physical and mental well-being can only be promoted through a comprehensive health care program—one that provides for medical, dental, nutritional, and mental health services, each with preventive, diagnostic, curative, and rehabilitative aspects.

A comprehensive program implies a tying together of all the aspects of health care in a mechanism for continuing health supervision. When casefinding services are provided by themselves, as they so often are in community health programs, there is no assurance that curative or rehabilitative services will follow. Similarly, the identification of treatment resources does not in itself guarantee efforts toward casefinding and prevention. To overcome such fragmentation of health efforts, administrators of local Head Start programs are expected to design a system that will assure children of continuing health care. To obtain Head Start health funds, they are required to draw up a clear plan of how health services are to be provided the families participating in their program. The end point of this plan is to be the complete delivery of services to the child. Specifically the plan must provide for:

1. Casefinding procedures to include: (a) history and physical examinations at appropriate intervals; (b) laboratory tests, including blood and urine examinations, tests for intestinal parasites, and other tests as indicated; (c) vision, speech, and hearing screening; and (d) tuberculin testing.

2. Immunization and other preventive services. These services are to include protection against measles, polio, smallpox, and rubella and a combined immunization (DPT) against diphtheria, pertussis (whooping cough), and tetanus.

3. Identification of treatment needs, the obtaining of appropriate care, and assistance to families in the use of treatment resources.

4. Counseling Head Start teachers, other staff

members, and parents in understanding health needs, establishing good health practices, and obtaining health services.

5. Inclusion and integration of all ancillary services relating to health, guidance, and social services.

6. Preservice and inservice training for both professional and nonprofessional staff.

7. Maintenance of adequate records and progress reports.

8. Evaluation of the results of the health services as they relate not only to the individual child but also to the community's health delivery and educational systems.

Because children cannot seek out health services on their own, a health program without maximum participation of their parents cannot achieve its objectives. Such participation needs to take place at all levels of health planning and implementation so that the program for the child is acceptable to them, is followed by them, and has a continuing effect on the family's health practices.

The foregoing are the goals. The system of health delivery within Head Start, however, varies from community to community, depending upon local customs and the funds and manpower available. The national and regional offices of the Office of Child Development help promote comprehensive care by developing instructional materials, allotting Federal funds to local programs, and providing technical assistance to local communities in the development of their programs. Guidelines for the Head Start health program are provided in a booklet,[1] which is available on request from the Washington or regional offices of the Department of Health, Education, and Welfare, through the Office of Child Development.

Head Start health funds are granted to local programs to supplement existing health resources and to provide Head Start administrators with staff to carry out the health plan. The children in Head Start programs receive health services through local health departments, the school system, medical centers, medical and dental schools, physicians and dentists in private practice, and comprehensive neighborhood health centers where they exist.

Since appropriate nutrition is a prerequisite both to good physical and mental development in children, Head Start's nutrition program is an important complement to its health program and vice versa. Through the nutrition program children in Head Start centers sit down with their teachers to hot meals and snacks and learn to become familiar with nutritious foods. In addition, both the staff and the children's parents receive training in planning and purchasing food to gain the most nutritious value for the least cost and to establish good eating habits. Head Start nutrition kits, prepared in the national office, are widely distributed; local programs are encouraged to put nutritionists on their staffs and to carry on in-service training programs in nutrition for other staff members. Some Head Start directors have observed that children entering their programs whose brothers or sisters were previously enrolled are in better condition nutritionally than were their siblings, thus suggesting that the children's families have learned to apply wiser shopping and feeding practices and use of community resources.

Innovations

In addition to supporting the expansion and coordination of existing health services and helping people to learn to use them, Head Start serves as an innovator in health delivery systems. It has played a major part in the development of new types of paraprofessional workers, particularly of the community health worker and the preventive dentistry technician.

The tasks of the community health worker vary with communities.

In Detroit, for example, Head Start funds in 1969 supported a training program through the local community action agency to provide community health workers for PRESCAD, a federally aided project for the comprehensive health care of children and youth. The community health workers received an intensive 2-month training course given by a team of health professionals and technicians. This course, supplemented by continuous on-the-job training under the direction of a public health nurse, equipped the worker to perform the following tasks:

1. History taking.

2. General health appraisal, including status of growth and development.

3. Screening tests for defects in vision, hearing, and speech, and blood and urine examinations.

4. Recordkeeping.

5. Working on a continuing basis with the children's families to follow through with referrals to community resources for treatment of any abnormality detected.

In Denver, the University of Colorado Medical Center, with Head Start support, has trained technicians to perform developmental assessments of Head Start children as well as screening tests of their speech, language, hearing, and vision and to refer children with suspected defects to appropriate community resources for definitive diagnosis, treatment, and aftercare.[2]

The preventive dental health technician is a new occupation initiated by Head Start. In 1968 the School of Dentistry of the University of Puerto Rico received a Head Start grant to train four women from the Virgin Islands Health Department to perform certain tasks of dentistry. Subsequently eight women from Mississippi have received similar training with Head Start support. This type of health worker serves children and their parents directly by teaching them proper toothbrushing techniques, the self-application of fluoride, and principles of hygiene. The dental health technicians also look for dental disease in children, referring those with dental problems to appropriate resources for care.

The development of such new types of health workers may prove to be an important contribution to the critical national shortage of health manpower. At the same time these new occupations are opening up dignified, meaningful careers for economically disadvantaged people.

Technical assistance

To help local Head Start programs plan and carry out comprehensive health care services, the Bureau of Head Start and Early Childhood has provided for technical assistance through several mechanisms.

1. Under a contract with the American Academy of Pediatrics, the Academy assigns a pediatric consultant to each local program. This physician visits the program two or three times a year and is available at any time for consultation by telephone. The pediatric consultant assists in program planning, identification of resources, mobilizing these resources to participate in the Head Start program, and improving the communication between the Head Start staff and the professional persons who reside in the community. For example:

- One pediatric consultant on visiting the community to which he was assigned found an excellent health coordinator for the program and helped her make arrangements with a group of practicing pediatricians to provide complete medical care for the children in Head Start.

- Another pediatric consultant established a mechanism for stimulating communication between the Head Start staff members and the children's parents that resulted in better understanding and use of health services.

- Still another pediatric consultant, on the request of a university, conducted a training program on health for Head Start directors, teachers, parents, and participating medical personnel.

2. Under a contract with the Division of Dental Health, Bureau of Health Manpower, National Institutes of Health, dental consultants are provided to help local Head Start groups establish plans for the identification and correction of dental problems of children in Head Start. The dental health consultants have helped develop plans for children to receive not only dental examinations, but also prophylaxes, topical application of fluoride, restoration of decayed teeth, and proper management of other dental problems. Approximately 50 percent of Head Start health funds are used in providing dental care to Head Start children.

3. Fifty-three Regional Training Offices have been established to assist local Head Start programs. Staffed by experts in various aspects of child development, they provide technical assistance to local Head Start programs on a continuing basis. Their services include training in the interdisciplinary approach to child development and help in identifying the need for medical consultation and in finding ways of mo-

Learning to clean his teeth is part of this child's dental health education in a Head Start child development center.

bilizing community health resources to serve the Head Start child. In addition, consultants in various fields from Head Start's national and regional staff provide help in planning and implementing Head Start health programs.

Evaluation and findings

Since the beginning of Head Start in 1965, the program has included a continuing evaluation of its health aspects in an effort to determine the—

- Health status of the children in the program.
- Adequacy of resources to meet the children's needs for treatment and aftercare and of the program's use of such resources.
- Degree to which health problems detected in children have been followed up with appropriate treatment.
- Sources of the health care provided.
- Methods of delivering such care.
- Costs of care.
- Effects of the health services on the child, the family, and the community.

All of these objectives have not yet been achieved. Efforts to determine the costs and effects of the services provided are still in the embryonic phases as tools to obtain this kind of information are being developed.

Subjective observation would indicate that in many communities there has been constructive change in health behavior, attitudes, and practices in families that have been involved in the program but the extent to which such changes have occurred has not as yet been objectively assessed. Perhaps the effect on the health programs of participating families can best be assessed by observing the health status of new enrollees who are siblings of former Head Start children.

Thus far, the evaluation of the health program has been carried on through four methods:

1. Under contract with the Bureau of Census, information is obtained on a 5 percent sample of children in full-year Head Start programs and on a 1 percent sample of children in summer programs.

2. Reports from local Head Start programs are requested on the disease conditions found in the children, the resources used for care, and the costs of providing medical and dental services.

3. Consultants submit reports of the health aspects of the local programs they have visited. In addition, annual reports from the pediatric consultants are submitted on forms designed to give an overview of the program.

4. Special grants are made to universities and other organizations on specific aspects of the Head Start health program, such as nutrition. Complete reports have not been received from any of the investigations now underway. However, the preliminary report of one nutritional investigation points to a direct relationship between adequate nutrition and satisfactory school performance.

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The Census findings show that more than 90 percent of the children enrolled in both summer and full-year Head Start programs in 1968 received medical examinations through Head Start. According to the children's parents these examinations revealed a health problem in 35 percent of the children who attended full-year programs and 43 percent of those who attended summer programs. These findings on the health status of children entering Head Start are compatible with information received from the other sources if they include children who had abnormal reactions to tuberculin tests, blood tests for anemia, or hearing or vision tests, those with dental caries or other dental diseases, and those with acute illness or injuries from accidents, as well as children with chronic medical conditions or major psychological problems.

According to responses to a questionnaire sent to the parents of the children found to have problems, 85 percent of those who were in full-year programs and 73 percent of those who were in summer programs received treatment for the defects. In 1968, 73 percent of the summer children who received treatment received it from a private practitioner, compared to 64 percent of the full-year children who received treatment—an increase over 1967, when the figures were 69.7 percent and 57.2 percent respectively.

Data for 1968 on the immunization status of children entering Head Start agree with the findings of the National Immunization Survey[3] that more children had DPT immunizations than had immunizations for polio or measles. However, on admission to the program, the Head Start children had lower rates for all categories of immunization than the children in the national survey sample.

Only 8.6 percent of the children from 1 to 4 years of age in the national survey sample had had no DPT immunization, as against 13 percent of the children entering full-year Head Start programs. The contrast would probably be even greater if the Head Start data included information on the children whose immunization status was reported as "unknown"—12.5 percent of all—and the 3.7 percent on whom there were no reports.

The National Immunization Survey found that 10.5 percent of the children of preschool age in its sample had not been vaccinated against polio, while Head Start figures show that 15.4 percent of the children entering full-year Head Start programs had never been immunized against polio. The contrast again would probably be greater if the 14.1 percent whose status was unknown and the 4.3 percent not reported were included in the calculations.

In regard to measles, the National Immunization Survey found one-third of the preschool age children in its sample unprotected with immunizations. The Head Start data shows that 60.8 percent were not protected either by immunization or having had the disease.

Since providing immunization is a Head Start program responsibility, many of the children who were unprotected by immunizations on entering the program have since been immunized. Figures for 1968 are not yet available. However, a followup study conducted in 1967 indicated that 85.4 percent of the children in Head Start had been fully protected with DPT, measles, polio, and smallpox vaccinations before they left the program.

The 1968 health reports also showed that on entering Head Start—

- Among the children given tuberculin tests, 1.9 percent of those in full-year programs and 2.2 percent of those in summer programs had positive reactions.

- Among the children tested for anemia, either by hematocrit or hemoglobin methods, 15 percent of those in full-year programs and 11 percent of those in summer programs were found to be anemic.

- Among the children given screening tests for hearing abnormalities, 4.9 percent of those in full-year programs and 6.1 percent of those in summer had abnormal test results.

- Among the children given vision screening tests, 8.4 percent of those in full-year programs and 9.2 percent of those in summer programs were found to have abnormal test results.

Continuing care

If the provision of comprehensive health care to Head Start children were met solely within Head Start facilities, it would be difficult to achieve the goal of introducing the child to a comprehensive program of health care that would continue after the child leaves Head Start. As one method of assuring continuing care, local Head Start directors are encouraged to introduce the children in their programs to other sources of health care in which they can continue throughout their childhood—such as the programs for the comprehensive health care of children and youth, established with support from the Children's Bureau under the 1965 amendments to the Social Security Act,[4] the neighborhood health centers established by community action agencies with support from the Office of Economic Opportunity, and other community resources. Head Start directors are also encouraged to see that families are enrolled in Medicaid or voluntary health insurance programs.

Only through the cooperation of all available health workers in program planning, mobilization and utilization of health resources, the creation of still more new methods of service delivery, the involvement of the families being served, and a willingness to depart from some of the traditional methods of health care, can the goal of achieving the optimum health care for all children be reached.

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a report from abroad . . .

FAMILY PARTICIPATION in HOSPITAL CARE for CHILDREN

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During the middle part of the 1960's the authors of this article visited about 150 medical facilities in what are known as "developing countries" in Africa and Asia to study the part played by the patient's family in care in the hospital.[1] We found all levels of medical care and treatment for children. At one extreme a hut in the bush served as a makeshift hospital where there were not enough beds to give one to each child. The well-meaning but virtually untrained staff members supported their efforts to minister to the sick by raising baby gorillas to sell to zoos. At the other extreme, within a few minutes' travel time, teaching hospitals were so new that they fitted completely into a modern university. There highly sophisticated physicians of professorial rank were applying the latest pediatric knowledge and techniques. But no matter what the level of medical care, we found nearly everywhere that the child had the security of the immediate love and care of his mother or other relatives for 24 hours every day.

Hospitals in Africa, South America, the islands of the Pacific, and many Asian countries are well acquainted with this practice. But Western scientists have paid it little heed. Our visits were made to learn whether the experiences in these countries might have any lessons for the West. The senior author was supported in part by the National Institute of Mental Health, for whom he was then working, and the junior author was awarded a small grant from the Division Fund.

In each hospital we asked the question, "Where is the family in this hospital?"

We found members of the patients' families in almost all hospitals. Sometimes we found it helpful to rephrase our basic question to ask, "Where is the patient without his family?" The answer told us where we would find the points of real separation anxiety. For example, it was exceptional to find any relatives with the patients who were mentally ill, retarded, or who had Hansen's disease (leprosy). However, we did find children living with their mothers in a leprosy settlement in Biafra under the watchful eyes of an Irish missionary nurse and consultant physicians. Thus, if the patient was a mother with a nursing baby or an older child who could not be cared for otherwise, we would find the child with her.

To understand why relatives come or do not come to the hospital, it is necessary to look at the child, his family, the community from which the child comes, the hospital and its staff, and the complex interrelationships among them. We are here restricting our observations mostly to situations in which the patients were children.

The family

Let us look first at the family in the developing countries. In general, in such countries, families extend kinship relationships further and more actively than do American families. With many relatives, there is no problem of having enough family members to spell one another at the hospital and to look after those left at home. In Ghana we were told, "To know a man's family you have to know a thousand people."

The few statistics available show that women more generally than men escort patients to the hospital but men more than women seek treatment in hospitals. In cities, however, women are increasing their use of hospitals, even for childbirth. A general hospital in Kinshasa in the Congo keeps up a steady rate of 3,000 deliveries a month. At noon the husbands stream in to bring the midday meal.

Many factors induce relatives to come to the hospital with patients. One is the pressure to carry on prescribed family functions—such as cooking, which is woman's work. Another is the custom of breast-feeding babies, so characteristic in these countries that an infant usually remains with his mother even when she is the patient. Many mothers bring their babies with them when they come to the hospital to look after their husbands or older children.

Pakistan is one of the Moslem countries in which many relatives must accompany a man to show his status in the community. A physician at one Pakistani hospital described such a troupe of relatives as "the bridal procession of the patient." In many African countries, a relative who is not at the bedside when a patient dies will be blamed for sorcery. This practice encourages members of the family to be present at the deathbed or to make strong efforts to bring a patient home to die. Some hospitals prefer that families take a dying patient home, because a death on the wards might be blamed on the staff and could lead to a mass exodus of patients.

Relatives often come along with

patients to protect family secrets—an especially potent reason in Liberia, where secret society membership is a primary social obligation. Community pressures are strong to assume responsibility for the young, to revere the aged, and visit the sick.

On the other hand, sometimes the cost of keeping the patient at home is so great that the family abandons him. For example, in some areas families commonly reject children with burns or who have otherwise been handicapped or disfigured, fearing that they will be unable to get a job or to marry when they grow up. The family may also cast off a relative they regard as incurable, such as a leper.

Occasionally a nursing mother remains at home when one of the members of her family is hospitalized.

Distance seems of minor importance. Africans and Asians walk many hundreds of miles to be treated at a certain hospital or by a particular doctor: almost invariably a relative goes along. In India we found patients who had traveled 2,000 miles to reach a particular clinic. However, when a family lives close to the hospital, the relatives may spend less time at the hospital than when they have come from a distance. Much depends on the availability and the expense of transportation.

Hospital policies

We found that the nature of the hospital is perhaps the most important factor in determining the presence or absence of the family. In many hospitals, including children's hospitals, the staff members welcomed the families of their patients. However, teaching hospitals built with foreign aid—attempting to qualify for international credentials, striving to be centers of research, and staffed extensively by Western expatriates—had limited family participation. In such hospitals we were often taken to see a magnificent laundry, a simulated ward for instruction, or some piece of laboratory apparatus.

What the teachings of such centers augur for the future of family relationships in the hospitals in these countries remains to be seen. In India some teaching hospitals are being set up or remodeled in the style of the rural hospitals in which most of the medical school graduates will work.

Hospital policies and staff attitudes strongly determine how much the family participates in caring for the patient. Each hospital we visited had a family policy—either explicit or implicit. Sometimes this was dictated by the government. For instance, in Zambia, the government policy included payment not only for the child's hospitalization but also for his mother if her presence is judged essential to the patient's recovery. In another African country, using hospital resources to help family members stay in the hospital was prohibited, but hospital authorities often looked the other way.

Local hospital policy tends to be more powerful than national policy in any case. Often we discovered a hospital's policy by asking: "Where do members of a patient's family go in the hospital when they cannot be with him?" The attitude of the medical officer in charge usually explained the answers. For example, to keep mothers out of the wards, the physician-director of a hospital in Kenya set up a verandah for their use. The mothers found it cold, and—in spite of an occasional midnight raid by the staff—usually sneaked inside to comfort their children and to keep themselves warm.

The director of a hospital in Tanzania told us that the family policy "cannot be left to hit or miss. If it is thought through, the families create no difficulties." In Nigeria a hospital director told us, "It is important to have the role of the family in the hospital defined. The doctor must tell the family how far it can go . . . he determines whether or not staff trust family members and give them recognition."

One doctor planned to make his hospital rounds during the afternoon when he knew members of the families would be visiting. On the other hand, a few doctors ordered the families out. After an American doctor who ran a pediatric ward in one African hospital did so, he found the mothers clustered around the windows reaching through and touching the hands of their lonely children.

In some hospitals, because a policy had not been set by the doctor in charge, we found open warfare between the families and the nurses. However, in many places we were convinced that the nurses had more influence than doctors in determining the policy toward the family. Indigenous nurses tended to give in to families; most nurses from the West had early in their tenure come to some resolution of the differences between their training and the local family and hospital customs. Some nurses saw the patient as their only responsibility; some saw the whole family as the hospital's clients. Some nurses seized the opportunity to teach

Mothers in residence and their children who are ambulatory patients in a hospital near Leopoldville in the Congo carry on their regular activities without interruption when they are moved out-of-doors so that the children's ward can be cleaned.

In a hospital near Bangalore, India, a mother provides nursing care as well as emotional support for her child who is suffering from a neurological disturbance.

good health habits to the patient's relatives and to treat them at the hospital.

Much seemed to depend on the nurse's differentiation between the roles she assumed and those she allotted the patient's relatives. The nurses reserved treatment functions for themselves and the doctors, but how they defined treatment varied from hospital to hospital, and depended upon their willingness and time to train mothers. We learned how nurses regarded the family when nurses told us what they alone should do, and what mothers were expected to do. In one hospital mothers would be given the tasks of giving the child his medicine at the specified time and taking and recording his temperature, while in another hospital even bathing the patient would be regarded as a part of the nurse's job.

Relatives' roles

Relatives took on many tasks, however. In some places they only served as informants about the child at the time of admission. In others they provided full physical care: prepared food; fed, bathed, dressed, exercised, and toileted the patient; did laundry; cleaned the room; dressed the patient's hair; and watched over him. The relatives were effective communication links, keeping the nurse and doctor informed about the patient and other important matters, orienting the patient to the hospital, telling him about his illness and his treatment, sending news back home to the village, and bringing messages to the patient. In some hospitals, the staff even used the patient's relatives to instruct patients about their condition.

Problems arose only where mothers and nurses were allowed to compete, and where nobody took the time to define the separation of functions. Mothers could be as competitive as the nurses: some who did not like what the nurses were doing had no compunction about doing the work over. Occasionally a mother picked up her child and moved him to another hospital or took him to a native practitioner. Sometimes she persuaded all the rest of the mothers to leave the hospital in protest—a maneuver that greatly increased the sensitivity of staff to the personal feelings of the families!

Many hospitals did a great deal of improvising to make the families feel at ease. They kept newborn babies next to their mothers. In the wards for older children, the hospital in Kinshasa had built cubicles of glass, with bed, crib, wash basin, and storage space that separated each mother and child from the others on the ward. The point was to prevent cross-infection while keeping them from feeling isolated. At the College of Medicine, in Taipei, Taiwan, the beds were especially made so that mother and child—who normally sleep together at home—could be accommodated in the small rooms.

In some places porches, sheds, hostels, and villages were used to house the relatives of hospital patients. Even so, many relatives often made nests under the patient's hospital beds, sleeping on the floor as they did at home. We saw the "ultimate" in family participation: four relatives were sleeping on the bed, and the patient—who was frightened of the bed because he had never slept in one—was on the floor under it.

Many hospitals allowed their patients' relatives to build a kitchen where they could go to cook what they liked, to think things out, to gossip and laugh, or be together in crowds instead of being shut up in separate rooms. Other hospitals provided the patients' relatives with facilities for storing possessions, visiting, tending to sanitary needs, learning about health care, and playing.

Such efforts to give the members of the patient's family a feeling that the hospital is a natural part of the community helped overcome suspicion, anxiety, and timidity. As one German doctor said, the hospital then is "not cutting so much the roots." In contrast, handsome modern hospitals modeled on those in industrial countries often frightened the families away.

Premature babies

Freedom for experimentation also promoted family participation. The program for premature babies at Baragwanath Hospital outside Johannesburg, South Africa, is an outstanding example. The hospital could not afford incubators, so Erich J. Kahn, M.D., now head of pediatrics at Harlem Medical Center in New York City, turned the whole ward for prematures into an artificially heated and humidified incubator. He daringly set up facilities for mothers in an adjoining ward and required them to live in and help care for their infants.

We arrived at Baragwanath just before lunch to visit one of two identical units that took care of 80 premature babies. Lunch was served to mothers on a porch where some of them slept. All the mothers were dressed in hospital clothes and wore white caps over their hair, even a woman with an immense woven coiffure. The head nurse rang a bell; the mothers scrubbed as if they were going into surgery. They put on masks and lined up at the door to the babies' room for a squirt of antiseptic on their hands. Then, happily they filed into the room; each took up her station on a chair beside her baby expressed her milk into a bowl, and took it to the nurse who recorded the nonnt to be sure the mother was not ying to "dry herself up".

Each of these mothers had begun to ke care of her baby from birth; she d him by whatever method possible, nd by the time he weighed 4½ pounds, e was put to the breast, even if he eeded supplemental feeding. Through is experiment the death rate of the remature babies had been reduced om 70 percent to about 20 percent—a vel equal to the rates in New York ity and London.

Curiously, Dr. Kahn's efforts to duplicate his program in Harlem, where here is an unduly high premature irth rate, met a wall of resistance. ome opponents said they feared the abies would get second-rate care because no comparable model existed in he best hospitals in this country.

enefits

Although there are drawbacks in etting relatives have free access to atients in the hospital—as they have n developing countries—there are also nany benefits: overworked staff members are able to use their time for professional functions; money can be spent or drugs and treatment instead of asic domestic provisions; and the uality of care is raised. For children who are protected by the rituals of family relationships, regular continuing contacts with parents and relatives offer more psychological support than any contrived expressions of affection and concern or any gift.

Where families are allowed freely in the hospitals, patients are more comfortable. They are insulated by their relatives when they need to be sheltered; when they are lonely their relatives help them have contact with other patients, with other members of their families, with the hospital staff, and the community at large. Psychologically they feel secure. We noticed how relaxed the children were; they seldom cried, banged their heads, or rattled the bars of their cribs. In fact, mostly they were on big beds that gave them comfort and scope. They could remain as active as was good for them under the watchful supervision of their mothers or other relatives. The noisiest children's wards were those in which mothers were not allowed.

Members of the patient's families grow in their understanding of illness and health. They learn how to monitor the patient's condition if they do not already know how. Being in the hospital around the clock, they are less likely to panic needlessly as changes occur in their patients. By the same token, the staff is more likely to take the patient's relatives seriously when they come to them in alarm. The hospital becomes a living school that trains agents to work for medical advancement, sanitation, and public health at home and in the community. If hospital staffs are not always enthusiastic about having families present, at least they usually acquiesce.

In our own country, when we increase our efforts to overcome the isolation of patients from their families, we shall be changing policies on a nationwide scale. We shall be forcing serious examination of existing policies about the place of the family in our national hospital and health programs. We shall be demanding changes in the laws and regulations that block humanization of patient care.

We shall be striking at the very foundations of professional careers and institutions in asking health insurance plans, group health schemes, union contracts, and Federal funding to support family participation in hospitals and care for the sick. We shall be calling for revisions in the standards for hospital safety, construction, and professional practice. We shall be asking hospital administrators to change their methods of accounting and record-keeping, their rules, and regulations. We shall be demanding that businesses and industries that profit from the technology of our hospitals develop the heart to invest in families.

Participation of the family in hospital care is not an exotic curiosity, but a natural expression of family conviction strongly adhered to in three-fourths of the world. The practice is followed because it is a humane response to the rights of children. We believe that access to the best in health care is a right for all the children in our country. In our minds, it follows that family access to children in hospitals is equally a right. Thus, we hope that professional persons trained to work with children in hospitals will join us in translating such rights into realities.

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[1] Bell, John Elderkin: The family in the hospital lessons from developing countries. U.S. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health, Chevy Chase, Md. PHS publication No. 1933. 1969.

for parents

VIOLENCE AND YOUR CHILD. Arnold Arnold. The Henry Regnery Co., Publishers, 114 West Illinois Street. Chicago, Ill. 60610. 1969. 224 pp. $4.95.

BETWEEN PARENT AND TEENAGER. Haim G. Ginott. The Macmillan Co., 866 Third Avenue, New York, N.Y. 10022. 1969. 256 pp. $5.95.

THE EMOTIONAL CARE OF YOUR CHILD. David Abrahamsen, M.D. Trident Press, Rockefeller Center, 630 Fifth Avenue, New York, N.Y. 10020. 1969. 287 pp. $6.95.

PARENTS-CHILDREN-TEACHERS: communication. Association for Childhood Education International, 3615 Wisconsin Avenue NW., Washington, D.C. 20016. 1969. 74 pp. $1.75.

IF YOUR CHILD IS HANDICAPPED. William C. Kvaraceus and E. Nelson Hayes. Porter Sargent Publisher, 11 Beacon Street, Boston, Mass. 02108. 1969. 413 pp. $7.95.

THE SECRET WORLD OF THE BABY. Beth Day and Margaret Liley, M.D. Random House, Inc., 457 Madison Avenue, New York, N.Y. 10022. 1969. 113 pp. $3.95.

A PARENTS' GUIDE TO LEARNING PROBLEMS. Margaret Golick. Quebec Association for Children With Learning Disabilities, 6338 Victoria Avenue, Suite 11, Montreal 252, Quebec, Canada. 1970. 24 pp. $1.

HOW NOT TO KILL YOUR CHILDREN. (by a family doctor). George Allen and Unwin, London, England. U.S. Distributor: Humanities Press, Inc., 303 Park Avenue South. New York, N.Y. 10010. 1969. 265 pp. $5.50.

EXPLAINING DIVORCE TO CHILDREN. Edited by Earl A. Grollman, with an introduction by Louise Bates Ames. Beacon Press, 25 Beacon Street, Boston, Mass. 02108. 1969. 257 pp. $5.95.

BOOK NOTES

LANGUAGE LEARNING AND COMMUNICATION DISORDERS IN CHILDREN. Gertrud L. Wyatt. Foreword by Dorothea McCarthy. The Free Press, The Macmillan Company, New York, N.Y. 1969. 372 pp. $11.50.

Part I of this book describes the patterns of interaction between adults and children through which a child learns how to communicate and Part II discusses disorders of speech and language development in children. The author, director of psychological and speech therapy services in the public schools of Wellesley, Mass., explains normal processes of acquisition of language by a child as a basis for understanding deficiencies in language development.

To illustrate her concepts, the author gives two detailed clinical studies, one of which involves her own child who became a stutterer. She perceives the acquisition of language as essentially a process of learning through a series of interrelated, but distinctive, stages of development, with the mother providing the primary speech model, verbal stimulation, and corrective feedback for the child. Some forms of mother-child interaction, such as a continuous and affectionate relationship manifested in frequent verbal and nonverbal communication, facilitate language development, the author maintains, while other forms, such as a mother's use of advanced vocabulary and complex sentence structure, interfere with it.

According to the author, stuttering arises from a developmental crisis caused by a disturbance in the mother-child relationship at a time when a child is faced with learning new patterns of a more complex nature. The disturbance leads the child to compulsive repetition of effort, to fixation at his stage of development, and active hostility toward his mother, thus impeding his ability to learn language correctly.

From this theory, the author has formulated three distinct patterns of mother-child therapy for stuttering children of preschool age, elementary school age, and adolescence. She reports on studies of these and other patterns of treatment conducted in the Wellesley schools with stuttering children, children with articulation difficulties, and children with motor-perceptual as well as language disabilities.

YOUNG CHILDREN AND THEIR DRAWINGS. Joseph H. DiLeo, M.D. Bruner/Mazel, Publishers. New York, N.Y. 1970. 386 pp. $12.50.

A child tells about himself—his attitudes, feelings, and intellect—through his drawings, according to the author of this book. Illustrating his thesis with 345 figures, most of them drawn by preschool children, he points out that a child draws what impresses him emotionally and mentally, instead of merely copying what he observes visually.

The first section of the book deals with usual and normative drawings. The author notes, for example, that a trunkless human figure with an enormous head, gogglelike eyes, and threatening arms and hands is common to drawings of children under 5 years of age among various economic levels and races.

The second section of the book deals with the unusual and deviant, treating the use of drawings as diagnostic aids.

WAGES OF NEGLECT. Robert Coles and Maria Piers. Quadrangle Books, Inc., Chicago, Ill. 1969. 200 pp. $5.95.

The initial prescription for starting the neglected child on the road to development is to mother him and give him an opportunity to play, according to this book, which explores the effects of society's neglect on children. Based on their work with culturally deprived children, the authors—a research psychiatrist at Harvard University and the dean of the Erikson Institute for Early Childhood Education in Chicago—describe problems of poverty and what they call "uprootedness," the conflicts and tensions that a family faces upon moving from the security of a rural home into the unsafe environment of a city slum.

The authors report on four projects that they regard as having fostered development of children:

- The Child Development Group of Mississippi, in which teacher-mothers were trained at weekly workshops to operate preschool centers.
- The efforts of the St. Agatha Home for Children in Rockland County, N.Y., to help a group of deprived preschool children from Spanish Harlem put their feelings into words.
- The experience of the Hamstead Clinic in England in helping six young Jewish children, who had been rescued from a Nazi concentration camp in 1944, overcome their hostilities, establish ties with adults, and develop emotionally.
- The Boston North Point Project, which was designed to improve the living conditions of parents and children in abject poverty "while simultaneously buttressing their egos, thus beginning the chain reaction that leads to self-help and independence."

THE PSYCHOANALYTIC STUDY OF THE CHILD. Volume 24. Ruth S. Eissler and others, editors. International Universities Press, New York, N.Y. 1969. 550 pp. $12.

This volume contains 20 papers that discuss current approaches to and developments in the field of psychoanalysis. Its four sections include contributions to psychoanalytic theory, aspects of normal and pathological development, clinical contributions, and applications of analysis. Among the clinical contributions are papers on borderline states in children, as differentiated from neurosis or psychosis; a study of drug-taking adolescents; and the psychodynamic meaning and pharmacogenic effect of drug use in adolescents.

COME FROM THE FOUR WINDS: the story of Youth 'Aliya. Chasya Pincus. Herzl Press, New York, N.Y. 1970. 333 pp. $6.95.

This book recounts the experiences of some of the children who were brought to Palestine and Israel by Youth 'Aliya, a movement that has served 120,000 Jewish children from more than 50 countries since its inception as a rescue operation in Nazi Germany in 1934. ("'Aliya," a Hebrew word for "ascent," refers to the return of Jews to Israel.) The author describes the efforts of Youth 'Aliya to save children from ghettos and concentration camps throughout Europe and the Middle East as the persecution of the Jews intensified before and during World War II.

Her stories, drawn from interviews with Israeli men and women who grew up as wards of Youth 'Aliya in kibbutzim and youth villages, point out some of the problems of adjustment of young children and adolescents who are separated from their parents. Since World War II, the author reports, Youth 'Aliya has expanded its role as a child welfare organization by taking responsibility for children with special problems whose families live in Israel as well as children who have come to Israel from other countries of the Middle East and North Africa. She notes that the Youth 'Aliya educational programs—originally focused on agriculture and social responsibility—have been broadened to include vocational training, technical training, and college preparatory curricula.

GUIDES and REPORTS

FAMILY PLANNING: an option for all people? National Federation of Settlements and Neighborhood Centers, 232 Madison Avenue, New York, N.Y. 10016. 1969. 88 pp. $1.25.

Considers the questions involved in extending a real choice to individuals of whether or not to use birth control methods.

SERVICE DIRECTORY OF NATIONAL ORGANIZATIONS: voluntary and government. National Assembly for Social Policy and Development, 345 East 46th Street, New York, N.Y. 10017. 1969. 194 pp. $6.

Outlines the purposes, programs, services, and organizational structures of 121 major national health, welfare, and recreational agencies and provides information on how their services can be obtained in local communities.

THE DAY CARE NEIGHBOR SERVICE: a handbook for the organization and operation of a new approach to family day care. Alice H. Collins and Eunice L. Watson. Day Care Neighbor Service. Field Study of the Neighborhood Family Day Care System, 2856 Northwest Savier, Portland, Oreg. 97210. 1969. 57 pp. Single copies available from the Service.

Describes a program in Portland, Oreg., in which working mothers can arrange privately for family day care for their children with neighbors who have been certified as day-care mothers by the program. (See CHILDREN, July–Aug. 1966, pp. 135–140.)

VISION SCREENING OF PRESCHOOL CHILDREN. Leon J. Taubenhaus and Anne A. Jackson. Charles C Thomas, 301–327 East Lawrence Avenue, Springfield, Ill. 62703. 1969. 106 pp. $8.75.

Describes how to organize and conduct a community-wide vision screening program for children under 6 years of age, with specific suggestions for working in Head Start, health centers, and housing projects.

INNER-CITY EDUCATION: are we failing? Edited by William H. Dreier and John M. Earls. Department of Education, University of Northern Iowa, Cedar Falls, Iowa. 50613. 1969. 150 pp. $1.50.

Contains selected papers and reports presented at the Fourth Professional Education Seminar at the University of Northern Iowa.

TEN CASE STUDIES: an aid for staff development in child-care institutions. Eva Burmeister and Roy Kuhn. Department of Social Work, University Extension, University of Wisconsin-Milwaukee, 3255 North Maryland Avenue, Milwaukee, Wis. 53201. 1969. 97 pp. $3.

Presents actual episodes involving children in residential group care, and principles of child care emerging from these episodes.

THE DESIGN OF A PRE-SCHOOL "LEARNING LABORATORY" IN A REHABILITATION CENTER. Ronnie Gordon. New York University News Bureau, Washington Square, New York, N.Y. 10003. 1969. 61 pp. $3.

Describes the physical layout and equipment of an experimental nursery school for multiply-handicapped children and the purpose behind the design.

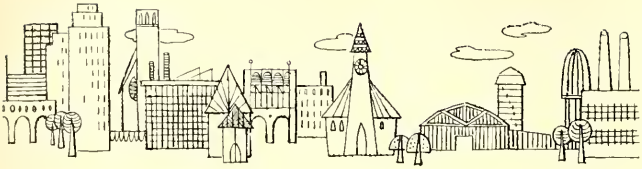
A FOLLOWUP STUDY OF ADOPTIONS: postplacement functioning of adoption families. Elizabeth A. Lawder, Katherine D. Lower, Roberta G. Andrews, Edmund A. Sherman, and John G. Hill. Child Welfare League of America, Inc., 44 East 23d Street, New York, N.Y. 10010. 1969. 232 pp. $4.

Reports the findings of a study of the postadoption adjustment of parents and their adopted children in 200 families served by the Children's Aid Society of Pennsylvania and pinpoints factors of parental functioning that affect the outcome of adoption.

REPORTS ON HUNGER WORKSHOPS IN TWENTY CITIES. National Council of Negro Women, Inc., 1346 Connecticut Avenue NW., Washington, D.C. 20036. December 1969. 52 pp. Free.

Contains recommendations for eradicating hunger in the United States from "poor, hungry, and concerned citizens," who met in 20 community workshops in 1969 under the sponsorship of the National Council of Negro Women and 74 other national organizations.

HERE and THERE



White House Conferences

The convening of the White House Conference on Youth in Washington, D.C., originally announced for June of 1971, has been moved up to February of that year according to an announcement made by Stephen Hess, the conference's national chairman and staff director, in mid-June. With the purposes of increasing the channels of communication between youth and adults on important national issues and of involving young people in the decision-making process, the conference is expected to include more than 1,000 people, two-thirds of them between the ages of 14 and 24, representing the various racial, ethnic, and socioeconomic segments of the population as well as various levels of education.

The conference will be planned by ten task forces, each with two chairmen—one youth and one adult—and each assigned to a specific area of concern, such as foreign relations, the environment, race relations, drugs, education, and the draft. The task force chairmen are meeting in July to decide how to select the members of their task forces, which are to follow the two-thirds-one-third youth-adult formula. The full task forces will convene in August to set the agenda for the Washington conference, decide the process of delegate selection, and determine how to formulate their reports to the conference.

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The format of the national White House Conference on Children to be held in Washington, D.C., December 13–18, establishes seven major program areas, according to Stephen Hess. These are subdivided into 26 forums, which will include group discussions as well as the use of films and other audio-visual materials, visits to institutions that serve children, role playing, and other means of presenting and exchanging ideas.

Selected from more than 1,500 individual suggestions made by State Committees for the White House Conference, national voluntary and professional organizations, parents, children, and other consultants, the seven tentative program areas and forum topics are as follows:

Individuality: "I'm me;" emergence of identity—the first years; expressions of identity—the school-age child; crisis in values.

Learning: The future of learning—into the 21st century; creativity and the learning process; the right to read; confronting myths of education; educational hardware—instructive or destructive.

Health: Keeping children healthy—health protection and disease prevention; making children healthy—delivery of health care; children who are handicapped; children who are injured.

Parents and families: Changing families in a changing society; children and parents—together in the world; family planning and family economics; developmental day care services for children.

Communities and environments: Children without prejudice; "it's all where you live"—children and their physical and social environments; child development and the mass media; the child and leisure time.

Laws, rights, and responsibilities: The rights of children; children in trouble—alternatives to delinquency, abuse, and neglect; the child advocate; about the law—communicating the law's message to children.

Child service institutions: Meeting the needs of the 70's.

Each forum will have 10 to 15 working members including representatives of various professions, parents groups, and others. In preparing for the conference, the members of the forums may, at the discretion of their chairmen, listen to testimony of professional workers; study reports; participate in workshops; exchange ideas; and visit schools, day care centers, recreation programs and camps, hospitals, and other facilities that provide service to children.

The 100 representatives of national voluntary and professional organizations who comprise the WHC technical assistance committee will evaluate preliminary reports. Following the national conference, they will suggest methods for implementing the recommendations for action to meet the needs and solve the problems of children.

The regional conferences originally planned for November have been postponed to the spring and will be focused on the development of plans for implementing the conference recommendations.

The State Committees on Children and Youth have elected the following regional chairmen: Southwest, Mrs. Joseph L. Haefeli, chairman of the Colorado CCY, Greeley; Great Lakes, Raymond McClelland, former chairman of the Wisconsin CCY, Milwaukee; Midwest, Mrs. Clifford Jorgenson, chairman of the Nebraska CCY, Lincoln; Northwest, Mrs. James King, chairman of the Oregon Committee on the 1970 WHCCY, Taulatin; Northeast, William M. Schmidt, chairman of the Massachusetts CCY, Brookline; and Southeast, Mrs. W. Ed Hamilton, chairman of the Kentucky Commission on Children and Youth, Bardstown.

Public assistance

A national evaluation committee, set up by the Secretary of Health, Education, and Welfare in May to study the simplified method of determining eligibility for public assistance by declaration and to recommend improvements, will make a number of on-site visits during the coming year to welfare departments that use the new method. At its first meeting in Washington, D.C., in May, the committee visited the District of Columbia Department of Public Welfare to look at the simplified method in use.

Under Federal regulations, all States must have the simplified method in statewide use in programs of old-age assistance, aid to the blind, and aid to the permanently and totally disabled no later than July 1, 1971. All States but Arizona have completed tests of the method in programs of aid to families with dependent children (AFDC), or have tests currently underway. Because evaluations are still being conducted, no Federal decision has been made about mandatory use of the simplified method in AFDC.

With the simplified method, the applicant files a comprehensive statement of his income, resources, and personal circumstances on a form designed by the State welfare department. The form, when accurately completed, provides all information needed by the agency to determine eligibility and the amount of the assistance grant.

Armond C. Stalnaker, president of General American Life Insurance Co., St. Louis, Mo., is chairman of the evaluation committee. Members include welfare recipients and representatives from industry, labor, education, social welfare and national organizations.

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DIRECTOR AND CHIEF

Edward F. Zigler, professor and director of the child development program, Yale University Department of Psychology, and head, Psychology Section, Yale Child Study Center, became director of the Office of Child Development and chief of the Children's Bureau, Department of Health, Education, and Welfare, in mid-June. He was nominated for the Children's Bureau post by President Richard M. Nixon in April and his nomination was confirmed by the U.S. Senate on June 15.

The Office of Child Development which includes both the Children's Bureau and the Bureau of Head Start and Early Childhood, was set up in the fall of 1969 to coordinate children's activities throughout HEW.

Dr. Zigler served on the faculty of the Yale psychology department from 1959 until he assumed his duties with HEW this summer. He is a graduate of the University of Missouri at Kansas City, and earned a Ph. D. in clinical psychology from the University of Texas.

A fellow of the American Psychological Association and the American Orthopsychiatric Association, Dr. Zigler is also a member of the APA council of representatives; the research advisory board of the executive committee, National Association for Retarded Children; and board of directors, Day Care and Child Development Council of America. He has served as a consultant to the Office of Child Development, Office of Education, and the National Institute of Child Health and Human Development. He has held many other Federal appointments including membership on national committees for Project Head Start, Project Follow-Through, the National Laboratory for Early Childhood Education, and the Veterans' Administration.

Dr. Zigler's special interests include mental retardation and the effects of cultural deprivation on the development of children. He is the author of more than 100 research papers and reviews in the field of child psychology.

A planning grant was awarded by the Department of Health, Education, and Welfare in June to the State of Vermont for the development of a model State Family Assistance Plan that will be completely under Federal management. The grant will also identify some of the factors involved in the transition from a State-administered public assistance program to a federally administered nationwide program, such as the Family Assistance Plan now under consideration by Congress.

The grant calls for—

- Development of a model plan for Federal administration not only of the basic Federal benefits and the adult category programs, but also of the State supplemental assistance program.
- A survey of the needs for day care and manpower services within the State from which nationwide estimates can be projected.
- Day care planning and operation.
- Expansion of manpower services.

The model plan will identify and resolve problems arising from the integration of a State supplemental program into a federally administered Family Assistance Plan—for example, how to deal with different standards in the different categories of assistance.

The grant will provide funds for development and operation of day care facilities and "seed money" to assist in the establishment of day care centers. State staff members will determine procedures for making payments to centers and day care homes.

Adoptions

Interagency cooperation between the Milwaukee County (Wis.) Department of Public Welfare and voluntary adoption agencies has resulted in placement in the past 2½ years of more than 200 children for whom adoptive homes otherwise would not have been found. For example, 124 black or racially mixed children were placed in adoptive homes in 1969, in contrast to only 10 black children in 1966.

In 1967 as in previous years the county welfare department had more children needing adoptive homes than it could place. On the other hand, voluntary agencies had more applications for children to adopt than they had children available. The effort to pool resources so that needs could be met began at the regular monthly meetings of adoption supervisors of the seven agencies. Cooperative efforts involved—

- A scheduled time at each monthly meeting for exchange of information about welfare department wards in need of adoption and couples whose homes had been approved for adoption by the other agencies.
- Use by the department of the Wisconsin Adoption Resource Exchange, which regularly distributes lists of names and brief descriptions of children available for adoption and available adoptive homes.
- A $10,000 contract made in 1969 by the county welfare department with the Catholic Social Services of Madison, Wis., for the placement of 25 children.

Less than 1 percent of the cooperative placements did not work out—a rate equal or slightly better than the department's record with its own placements. To facilitate interagency contacts, photographs and case records of the children available for adoption have been exchanged. The efforts have required mutual trust between social workers in different agencies, prompt responses to telephone calls and requests for information, and tolerance of differences in agency procedures and techniques.

The cooperative program is coordinated by Edna M. Levis, section supervisor for adoptions, Milwaukee County Department of Public Welfare.

Fetal studies

Studies to develop methods for diagnosing and treating congenital and hereditary diseases in the fetus are underway at the San Francisco Medical Center, University of California, with support from a 3-year grant of $253,869 made early this year by the John A. Hartford Foundation, Inc., of New York City. Under the direction of Louis K. Diamond, M.D., hematologist and professor of pediatrics at the university, the investigations will include an analysis of the amniotic fluid that surrounds the fetus in an effort to refine procedures for detecting chromosome abnormalities and metabolic disorders in the unborn child, to develop new procedures for detecting potential hazards to the fetus at the earliest possible point in prenatal life, and to develop therapeutic methods for prenatal treatment of congenital and hereditary abnormalities.

The investigators will look into the possibilities of using fetal surgery to correct malformations that may cause death in the newborn, of correcting chromosomal defects in the fetus to prevent mongolism in the infant, and of working out new ways to alter the course of a disease in the fetus.

For migrants

On July 1, 1970, a computer data bank, designed to furnish educational and health records of migrant children to school and public health officials within 24 hours of a request for information, started operations on a pilot basis in seven States in the middle and Southwest. Operated by the Arkansas State Department of Education under contract to the U.S. Office of Education, the computer bank will eventually be expanded to include the records of more than 200,000 migrant children in the 48 mainland States now served by the programs receiving Federal funds for migrant education under title I of the Elementary and Secondary Education Act.

The electronic system will supplant the dependency on manual transfer of records by the children themselves under the Uniform Migrant Student Record Transfer System, which has been in operation for more than a year. It will store six kinds of information on each migrant child: Specific patterns of mobility; school attendance, health records, and family data; scores on special tests; information on the child's interests, abilities, and needs; and analysis of basic data about the student; and general demographic data.

For the pilot study, terminals in Colorado, Kansas, Missouri, New Mexico, Oklahoma, and Texas will be linked to the central data bank at Little Rock, Ark. Other States will join the system later.

Income support

Payment of income supplements averaging $1,100 per year to 364 families with male heads in Trenton, Passaic, and Paterson, N.J., during the first 14 months of a continuing 5-year work incentive experiment, financed by the Office of Economic Opportunity, has increased their work effort, according to preliminary data released recently. Analysis of the data shows no evidence that work effort declined among those receiving income support payments between August 1968 and October 1969, according to the OEO report.

The experiment is being directed by the University of Wisconsin's Institute for Research on Poverty in association with MATHEMATICA, Inc., of Princeton, N.J., at a cost of more than $5 million. One purpose is to determine the degree to which income maintenance payments increase or reduce work effort. A total of 1,359 families in Scranton, Pa., Jersey City, and the three other New Jersey cities were selected to participate in the experiment.

While the experiment in many ways resembles the proposed Family Assistance Plan, it has two major differences: participants are not required to register for work or job training and no day care facilities are provided for their children.

In 1969 the participating families had an average of 5.8 members. The average age of the father was 35.6 years. About 36 percent of the families were white, 36 percent were black, and 28 percent were Spanish-speaking Puerto Ricans. Sixty-six percent of the heads of the families usually worked full time. The average family income at the beginning of the experiment was $4,248.

The income supplements are paid on a scale that guarantees the families total incomes equal to 50, 75, 100, or 175 percent of the poverty line—defined as $3,300 a year for a family of four. The supplements are reduced by 30, 50, or 70 percent as other income rises.

Figures show that about 53 percent of the 364 families receiving supplements had higher earned incomes and 29 percent had lower earned incomes at the end of the first phase of the experiment, while 43 percent of the 145 families not receiving payment had higher earned incomes and 31 percent had lower earned incomes.

The researchers found that heads of the low-income families considered job stability twice as important as any other aspect of work. Between 55 and 65 percent of the men said they wanted better jobs and would be willing to take training with a pay cut or to move to another city to obtain such a job.

The experiment also found that low-income families receiving supplements tended to reduce borrowing, buy fewer items on credit, and purchase more consumer goods. Costs of administering an income supplement program are estimated by the researchers at $72 to $96 per family per year, excluding work training and day care costs; costs of administering existing public assistance programs are estimated at $200 to $300 per family per year, excluding training and service costs.

Day care

To determine what constitutes good quality day care, the President's Science Advisory Council, Office of Economic Opportunity, and the Office of Child Development have invited 50 day care center administrators, child development specialists, teachers, parents, and government officials to participate in a day care workshop at Warrenton, Va., July 22 to August 2.

The participants will develop a statement of principles governing day care; identify and modify effective program models, materials, and products for day care use; and identify and develop effective training procedures. Following the workshop, prototype materials for many kinds of day care programs will be placed in the OEO Clearinghouse on Day Care. Publications will include a child development day care handbook and a manual. The materials will also be used by the White House Conference on Children.

Edward F. Zigler, director of the Office of Child Development, is chairman of the steering committee, and Ronald K. Parker, professor of educational psychology at City University of New York, is program director for the workshop. Other members of the steering committee include Barbara Biber, Bank Street College of Education, New York City; Urie Bronfenbrenner, Cornell University; John Davis, Minneapolis Department of Education; Luis Diaz deLeon, Colorado Migrants Council, Denver; Malcolm Host, Neighborhood Centers Day Care Association, Houston, Tex.; Jerome Kagan, Harvard University; Alfred Kahn, Columbia University; William Kessen, Yale University; Hylan Lewis, Metropolitan Applied Research Center, New York City; Francis Palmer, State University of New York at Stony Brook; Rosa Black Porter, Parent and Child Centers, Baltimore, Md.; Mildred Reed, Seattle Day Nursery; Julius B. Richmond, Upstate Medical Center, State University of New York; Kathleen Roderick, Alexandria, Va.; Thomas Taylor, National Capital Day Care Association, Washington, D.C.; and Frank Westheimer, Harvard University.

Homemaker services

Nearly 400 people attended the National Forum on Homemaker-Home Health Aide Services, convened in Washington, D.C., May 14–16, 1970, by the National Council of Homemaker Services, Inc. The participants included homemakers and home health aides from both public and voluntary agencies that provide such services, as well as supervisors, directors, and board members of such agencies, representatives of State Homemaker-Home Health Aide Councils, interested national agencies, the Federal Government, and the Welfare Rights Organization. With the theme, "An Agenda for Action," the conferees discussed not only ways of extending and expanding homemaker-home help services but also new uses for and ways of providing such services.

For example, a representative of a large agency in a metropolitan area told of the reduction of admissions to emergency shelters by 50 percent since the agency had initiated a service to provide homemakers to families in emergencies after office hours. Another discussant reported using homemakers to help modify children's behavior.

Among the obstacles to development identified through small group discussions were: (1) the absence of a reliable funding base; (2) the lack of a means of accreditation to assure quality of service; and (3) the lack of "hard" data for developing a method of accountability for the service provided. Among the proposals for action were: (1) increased efforts to obtain legislation to provide financial backing for such service; (2) encouraging the people who need the services to speak up; and (3) increased education of the public on what such services are and why they are needed.

READERS' EXCHANGE

BRANHAM: One-parent adoptions

I was interested in Ethel Branham's article, "One-Parent Adoptions," in the May–June 1970 issue of CHILDREN, since it describes an agency's experience in modifying its adoption practice in an effort to find permanent homes for hard-to-place children by placing them for adoption in one-parent homes. We have done some one-parent placements in Tennessee and have been pleased with the results. The children so placed have been girls and all the lone applicants have been single women. Some have taken children with gross handicaps.

Initially, some of our social workers were concerned about the lack of a father figure for the children to serve as a role model for self-identification. The apprehensive attitude of these workers toward one-parent adoptions changed significantly, however, when they were encouraged to think of the mature, responsible adults among their families and friends who have been successfully reared in one-parent homes and to recognize the many ways male companionship can be provided for children. We still have many unanswered questions regarding one-parent adoptions, but we believe that having only one adoptive parent is better for the child and more helpful to his efforts to achieve a sense of identity than growing up in a series of foster homes.

We feel more comfortable, however, with the idea of a lone woman adopting a child than a lone man, because we believe the mother figure to be a basic element in the home. There is a need for research in one-parent adoptions involving the single man, but this could only be based on many more such placements than have probably been made anywhere.

There is a growing feeling in adoption agencies that adoption workers need to be more aware of the risks adoptive parents can accept and that for far too long adoption workers have advised prospective adoptive parents about the kind of children for whom they can best provide a home. Adoption workers tend to label children and families without giving due consideration to the potentialities of some adoptive parents for rearing the less than perfect child.

Mrs. Branham refers to an evaluation of one-parent adoptions to be made by the Los Angeles County Department of Adoptions. I would think the results from such placements could not be known until the adoptees have reached adolescence or adulthood. Is there to be a control group of children adopted into two-parent families? By suggesting the need for research in this area I do not mean to imply that I do not respect the potentialities of one-parent families for making an important contribution to the adoption program.

Audrey V. Yarbrough
Supervisor of Adoption Services,
Tennessee Department
of Public Welfare,
Nashville, Tenn.

GARRETT: A foster parent's view

After reading Beatrice L. Garrett's article, "The Rights of Foster Parents," in the May–June 1970 issue of CHILDREN, I was ambivalent. I was "glad" that the Children's Bureau was publicizing the fact that foster parent organizations are developing in many places, for this has encouraged many social workers—from line to administration—to take the movement more seriously than in the past. I was also glad that the Children's Bureau is planning a National Conference of Foster Parents, for this has much to offer.

However, I was concerned because the primary question was not asked, a question that must be answered if foster parents' rights are really to make sense. The question is: What is the responsibility of the child care agency for the *growth* and *development* of a well considered foster care program (versus a placement program) and how do the responsibilities and rights of foster parents and social workers relate to such a program?

Without the agency first coming to grips, even in a marginal way, with the implications inherent in this question, talk about "role," "respect," "involvement," "support," "training," "legal protection," "salaries," "fair hearings," etc., becomes a battleground—encouraged by social workers and foster parents who are frustrated and dissatisfied with weak foster care policies. At present, two foster parent groups with which I am very familiar are caught up in exactly this kind of conflict. The agency they serve gives with one hand and takes with the other because little policy has been established and no one is assigned *full time* to do a responsible, developmental program.

Another group that organized on its own was casually told by representatives of the agency it served that its members might not be considered "satisfactory" foster parents if they continued to "cause trouble"—the "trouble" being their insistence on questioning the agency about what they had a right to expect from their social workers. Two other groups have become defunct because of the irregularity of the agency's support and the general feeling of the members that although the group keeps talking about the same problems nothing gets changed. A social worker actually suggested to one small group that its members were "spies" for supervisors and administrators.

In other instances, foster parents have spread damaging tales about an agency because there was no avenue available to them for their complaints about agency policy. I have seen supervisory social workers attack one another before a large group of foster parents over a matter that was impossible to settle on the spot because it had never been considered by administration. And recently, I have seen a social worker's union "use" foster parent groups in a most unethical way. To encourage this kind of friction even obliquely seems folly, and certainly takes up a great deal more time than good planning.

With the exception of points 11, 12, and 13 [concerned with payments and personnel policy], the foster parent rights listed in Miss Garrett's article are already granted and accepted by mature (I am not referring to age), capable, and responsible foster parents and social workers. The problem is that we don't have enough of this kind of person in either category. So we must ask the question: Why don't we establish dynamic foster care programs which by design and also by function include the rights and responsibilities of foster parents?

If in fact the agency is really responsible for the child in care, then the agency is basically responsible for developing such a program. It does not take a new budget, for I have seen some exciting things happen in an agency primarily through a shift of priorities.

It does mean that an agency must admit that foster care has not really had a chance because of the poor planning; assign to the foster parents' groups a full time foster care specialist who believes strongly in the team, understands group dynamics, and has direct contact with administration; quit playing the numbers game by merely counting new homes while ignoring the serious turnover in homes and the quality of the care given the children; utilize fully at many different levels the contributions of the skilled, experienced foster parent; and recognize the crucial need for a new and creative kind of training for foster parents and social workers to help them allow foster children *their* "rights"—for isn't this really what this is all about!

Ruby Kennedy
Foster parent for 15 years
Past President, Los Angeles County
Community Assistance to
Homeless Children

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textbooks

CHILD PSYCHOLOGY. Dorothy Rogers. Brooks/Cole Publishing Co. 10 Davis Drive, Belmont, Calif. 94002. 1969. 477 pp. $9.50.

THEORIES OF PSYCHOLOGY: a handbook. Ann F. Neel. Schenkman Publishing Co., Inc., One Story Street Harvard Square, Cambridge, Mass 02138. 1969. 482 pp. $5.75, paperback

CHILDREN AND ADOLESCENTS: a biocultural approach to psychological development. Theron Alexander Atherton Press, 70 Fifth Avenue, New York, N.Y. 10011. 1969. 365 pp. $8.95

CHILD & ADOLESCENT PSYCHOLOGY: behavior and development Gene R. Medinnus and Ronald C Johnson. John Wiley & Sons, Inc., 60 Third Avenue, New York, N.Y. 10016 1969. 787 pp. $9.95.

CHILD WELFARE: services and perspectives. Dorothy Zietz. John Wiley & Sons, Inc., 605 Third Avenue, New York, N.Y. 10016. 1969. 346 pp. $9.95

SOCIAL WELFARE: values, means and ends. Denald S. Howard. Random House, 501 Madison Avenue New York, N.Y. 10022. 1969. 46 pp. $8.50.

LANGUAGE DISORDERS OF CHILDREN: the bases and diagnoses Mildred Freburg Berry. Appleton Century-Crofts, Division of Meredith Corporation, 440 Park Avenu South, New York, N.Y. 10016. 1969 460 pp. $8.50.

U.S. Government Publications

ublications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

THE FAMILY IN THE HOSPITAL: lessons from developing countries. John Elderkin Bell, Ed. D. HEW, PHS, National Institute of Mental Health, PHS Publication No. 1933. 1969. 305 pp. $1.50.

Discusses the part played by families in 24 countries of Africa and Asia in aking care of members who are patients in hospitals or clinics and sugests extension of family activities to hospitals for the mentally ill in the U.S.

PUBLICATIONS OF THE CENTRE INTERNATIONAL DE L'ENFANCE: coordinated growth studies, 1951–68. Frank Falkner, M.D. HEW, PHS, Maternal and Child Health Service. 1969. 22 pp. Copies available from the author: Building 31, NIH, Bethesda, Md. 20014.

Lists authors and names of publications on human development issued under the auspices of the eight international research teams associated with the Center International de l'Enfance in Brussels, Belgium; Dakar, Senegal; Kampala, Uganda; Louisville, Ky., U.S.A.; London, England; Paris, France; Stockholm, Sweden; and Zurich, Switzerland.

PEOPLE POWER: a report of the conference. Published for the National Citizens Conference by HEW, SRS. 1969. 158 pp. $1.25.

Reports on the National Citizens Conference on Rehabilitation of the Disabled and Disadvantaged held in Washington, D.C., June 24–27, 1969.

DAY CARE—everybody's problem—volunteer to help in your community. HEW, OCD, Children's Bureau. 1970. 6 pp. Single copies free from the Bureau.

Stresses the need for day care services in this country and suggests what can be done to improve both the quality and quantity of day care services through the 4–C Program.

IMPROVING EDUCATION THROUGH ESEA: Twelve stories. HEW, Office of Education. OE Publication No. 20122. 1970. 72 pp. $1. Single copies free from the Office of Education as long as supply lasts.

Includes stories of 12 elementary and secondary school projects that show what has been done with Federal assistance to advance educational quality and services in our public schools.

RUBELLA. Jane S. Lin-Fu, M.D., HEW, PHS, Maternal and Child Health Service, Rockville, Md. 20852. PHS Publication No. 2041. 1970. 8 pp. Single copies free from MCHS.

Describes the symptoms of rubella, the damage it can do to unborn children whose mothers contract it in pregnancy, the importance of early examination and treatment of such children, and the need for a widespread immunization program to eradicate the disease.

BIBLIOGRAPHY ON SPEECH, HEARING AND LANGUAGE IN RELATION TO MENTAL RETARDATION, 1900–68. Maryann Peins, Ph.D. HEW, PHS, Maternal and Child Health Service, Rockville, Md. 20852. 1969. 156 pp. Single copies free from MCHS.

Lists publications relating to communication and the mentally retarded, including speech, hearing, and language behavior; remediation; habilitation procedures and educational programs; and methods of assessment of speech, hearing, and language.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; SRS, to Social and Rehabilitation Service; PHS, to Public Health Service.

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children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Robert H. Finch, *secretary*

OFFICE OF CHILD DEVELOPMENT
Edward F. Zigler, *director*

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children

Raising the Quality of Children's Lives

The Hospital and the Preschool Child

Black History in an Interracial Camp

Toward Reunion of Children and Parents

VOLUME 17 • NUMBER 5 • SEPTEMBER–OCTOBER 1970

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Two happy children in a day care program in a Brooklyn, N.Y., neighborhood house. That enjoyment of the present is itself a desirable goal for children that should not be overlooked in concentration on goals for their future is suggested by the emphasis put on the quality of children's lives by the new director of the Office of Child Development and chief of the Children's Bureau. (See pp. 166–70.)

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tions on how much can be done and how fast, but I am certain that we will not be short of exciting ideas: and whatever we do, we will proceed with enough caution to assure that the goal of quality is not lost in a feverish effort to "get things done."

Child development programs

One major effort will be to see that the programs for which OCD has direct responsibility are programs of high quality. Thus far OCD has administrative responsibility only for one direct service program, Head Start, the health and child welfare services formerly administered by the Children's Bureau having been transferred to other parts of HEW. There is a distinct possibility, however, that OCD may be called on in the near future to administer a massive day care program.

Head Start. Head Start has recently been under attack largely because a study made by the Westinghouse Learning Institute found that school children did not retain IQ gains made during a Head Start preschool experience.[3] Among other oversights, this study failed to recognize that there is a great variability in native ability, emotional maturity, and degree of social deprivation experienced by the Head Start child; that there is variability in the quality of Head Start programs and in the length of time children attend them—some children in the study had attended only 2-month summer programs; and that there is great variability in the quality of schools children attend after participating in a Head Start program. (A child who has had a good preschool opportunity to learn may be completely turned off by an inferior school.)

To my mind, however, the major fault of the Westinghouse study was its failure to recognize the multiple purposes encompassed in Head Start's view of the whole child in the context of his family: to introduce children to continuing comprehensive health services,[4] to improve their nutrition, to raise their self-esteem, and to involve their parents in plans to improve the quality of their children's experiences. Nor has the study recognized the fringe benefits of Head Start. Elsewhere in this issue there is a discussion of a study [5] showing changes that have taken place in communities largely through the influence of Head Start programs. (See page 193).

To assume that Head Start's main purpose is to raise children's IQ's is to greatly misunderstand the program. To expect that as a result of a few months' experience any child's IQ could be raised and stay raised regardless of what happens to him afterward is to believe in a kind of educational magic that does not exist. To regard such a goal as the only desirable goal for children is to denigrate the value of all other goals of child development, including that most important of all ingredients of social competence—a healthy personality.

Elsewhere I have expressed my opinion of what I have called "the environmental mystique," [6] the point of view that intelligence is trainable—that if you could just get the right experiences into children they would all be brilliant—a point of view that has grown out of the work of Hunt,[7,8] Bruner,[9] Deutsch [10] and others. These people are doing valuable research, but the popularization of their findings on cognitive development has resulted in expectations that children's ability to learn can be greatly enhanced through using technological gadgets and quick and easy techniques—expectations that can be destructive of both child and teacher when they fail to produce the desired effect. The recognition of the variability of native endowment has often been lost in the cognitive push, along with respect for qualities other than a high degree of measurable intelligence—patience, good humor, regard for others, to name a few.

As one of the planners of Head Start I am in perfect agreement with its goal of encouraging the development of every aspect of the child's endowment so that the uniqueness of his own personality can best be expressed. I am also in agreement with the program's emphasis on parental involvement in the achievement of this goal. This does not mean that I see no room for improvement in Head Start.

Today there are 1,800 local Head Start programs operating in an autonomous fashion but receiving funds, guidelines, technical assistance, and personnel training through the Federal government or institutions working under contract with the Federal government. In the sense of what they are doing to and for children, the quality of these programs ranges, I suspect, from very good to bad, with the latter representing only a very small fraction of the total. We do not, however, have exact information on the quality of all Head Start programs.

OCD, therefore, will attempt to get more detailed information about the current status of Head Start programs by instituting a quality monitoring system. As a first step a contract will be made for a study of 150 programs in regard to their total efforts for children—health, nutritional, and educational—and their effect not just on what the child learns but also on the child as a whole, his family, and the community. What we learn in this effort will be used in training members of OCD's regional staff in developing a continuous system of quality control.

Another effort, already underway, which will be effective in raising the quality of the curriculum aspects of Head Start programs, is a project of planned variations—a research effort to determine the effectiveness of various teaching methods as ntroduced in different Head Start centers.

Built-in methods of affecting the quality of Head Start programs through technical assistance and training opportunities will, of course, continue. One of Head Start's major achievements has been its production of a trained cadre of workers for preschool programs of any kind. Countless persons from the neighborhoods of Head Start centers, most of them parents of the children being served, have been trained to work in Head Start programs through its Regional Training Offices. Of these workers 7,500 have been taking college courses to prepare for career advancement.[11]

I am a firm believer in Head Start's policy of seeking talented people in the neighborhoods served to work creatively with children. But I do not believe that residence in a neighborhood in and of itself equips a person to work creatively with children. There are frustrated people in all strata of society who, because of their insensitivity to children's needs and responses, can do them great harm. If a Head Start program allows its enthusiasm for creating employment opportunities for neighborhood people to overshadow its responsibility to children, children may be endangered. While local control and parental involvement are sources of much of Head Start's vitality, they do not preclude accountability for the major charge: enhancing the quality of children's lives.

Day Care. At this writing OCD has no operating responsibility for day care, but it will certainly be involved in some way with the massive day care program envisioned in the pending Family Assistance bill,[12] if this should become law. To be ready for this eventuality, OCD has been designing proposed policies for administering such a program that would allow for a maximum of local flexibility and parental choice. It has also been working with the President's Science Advisory Council and the Office of Economic Opportunity in a project to develop principles and models of good day care practice for use by communities interested in establishing day care programs. To this end, a 2-week workshop of child development specialists and day care practitioners was held in Warrenton, Va., in July. The results of their work will be published soon.

Coordination of services

In regard to its charge to coordinate Federal programs for children, I see OCD's role as that of a guide rather than as a controlling authority.

There are already instruments for informational exchange and discussion among Federal agencies that might be strengthened to carry a coordinating function—the Interdepartmental Committee on Children and Youth, the Federal Panel on Early Childhood, and the Federal Regional 4–C Committees, all of which are staffed by OCD. Through the 4–C (Community Coordinated Child Care) program, OCD is stimulating coordinated planning among children's services in States and local communities.[13]

In addition, we are now planning the establishment of a secretariat within the Children's Bureau to map out all the Federal services affecting children. We can then spot overlapping areas, identify gaps in service, and so select targets for coordination and goals for our role as advocate for children.

Advocacy and innovation

The Children's Bureau during its 58 years of existence has served as an advocate for children, especially for children whom circumstances have made particularly vulnerable to developmental distortion. It has done this through setting standards for services of quality, providing technical assistance to the States in regard to the establishment and operation of services, drafting models for State legislation in areas affecting children, and recommending Federal legislation involving children's services. This type of effort will continue.

At present, for example, the Children's Bureau is mounting two related campaigns based on the belief that every child needs to grow up in the security of a family. Their purposes are (1) to swell the supply of foster families for children who, for a variety of reasons, need care away from their own parents; and (2) to increase the availability of prospective adoptive parents for hard-to-place children.

In addition we are planning to provide a channel within the Children's Bureau for fostering the Government's responsiveness to parents' concerns about their children. Called the Children's Concern Center, this unit will serve as a focal point to which members of Congress, voluntary and professional organizations, Federal agencies, and parents and other interested individuals can turn for answers to questions on any subject within the whole range of child development. Besides gathering information for transmittal to the inquirers, the Children's Concern Center will provide OCD with a means of learning what people are concerned about that might be translated into programs for children and their families.

Creative advocacy implies innovation. OCD will be an innovator, sometimes by suggesting appropriate services to other Federal agencies, sometimes by directly initiating a program on a demonstration basis, sometimes by acting as the catalyst for a mix of agencies from which a jointly operated program can emerge.

At present we are engaged in exploring ways to develop a program that we hope will have salutary effects not only on the quality of life of both teenagers and young children today but also on the future quality of parenthood in this country. The purpose is to promote opportunities for teenagers to work with the young in either a tutorial or child care capacity and to teach them the basic information and skills for child care. A recent OCD-sponsored conference of child development specialists, representatives of other professions concerned with children, and teenagers already engaged in working with young children has provided some valuable suggestions for pursuing this objective. (See p. 197). It is my fervent belief that teenagers and young children have something to offer each other and that a purposeful association between them can redound to the benefit of both.

We are also going to set up a section within the Children's Bureau to call attention to the needs of especially vulnerable children—children of migrants, retarded children, Indian children, and others.

We plan too to back a solid investigation of the effects of television on children—the good effects as well as the bad. Television is an integral part of the lives of the vast majority of the nation's children from their very earliest years, and yet we have no clear knowledge of the effects of long-term television viewing on children's socialization and development.

The whole child

OCD, with its limited resources, cannot be all things to all children, but it can serve as a conduit for the best thinking about children in this country to reach policymakers and people who work with children. In this way it may help to increase the sensitivity of those who affect children to children's needs as whole human beings.

It seems to me that the goals laid down for Project Head Start at its inception are appropriate goals for all efforts for children or young people of any age. In brief, these goals are:

- Improving the child's physical health and abilities.
- Encouraging self-confidence, spontaneity, curiosity and self-discipline.
- Increasing the child's capacity to relate positively to others, while strengthening his family's ability to relate positively to him and to understand his problems.
- Developing in the child and his family a responsible attitude towards society and creating opportunities for people to work together to improve social conditions.
- Helping the child and his family to an increased sense of dignity and self-worth.

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THE HOSPITAL AND THE PRESCHOOL CHILD

T. P. MILLAR

Nearly two decades ago the pediatric literature was filled with reports concerning the psychological damage hospitalization can do to a child. Recommendations to change the pattern of child care in hospitals were made, but rarely implemented.[1] Today concern over the risks of hospitalization for children's development is rising once again.[2]

In 1953, Prough [3] reported on 50 preschool and primary grade children who had been hospitalized for an average of 8 days. He found that 92 percent showed "significant disturbances in behavior not present prior to hospitalization." Nor were these simple, self-limited reactions. Three months later 15 percent of these children still showed signs of their difficulty.

There is little reason to believe that the psychological effects of hospitalization in children are any less today. Therefore it is pertinent to consider how such disturbances may be prevented, or, if that is not possible, how they can be so dealt with in the post-hospital period as to minimize their effect on the psychological health of the child.

What kinds of disturbances do children show after hospitalization? What is their meaning for the future well-being of the child?

"The worst part was when she first came home," the mother of a 4-year-old told me one day, her face a mirror of distress. "So fussy, and she wouldn't eat unless I fed her. She couldn't get to sleep, unless I stayed in with her. It was 3 months before she stopped calling out with bad dreams."

Another mother dealt with her distress about her little girl's post-hospital behavior by blaming the nurses. "She was all but trained before, but when she came home she was soiling and wetting again. I don't suppose they bothered to potty her. They just put her back in diapers because it's easier. I guess they're busy with all those sick kids."

A third mother was filled with self-recrimination about the effects of a hospital stay on her young son. "At first he kept saying, 'Why did you leave me there?' It's as though he blames me. Maybe I *should* have stayed with him. I could see I would just be in the way, but maybe I should have stayed anyway.

Now, 6 months later, he won't leave the yard to play. At first, I had to stand in the window where he could see me. If someone in a white coat, or even someone carrying a pair of scissors, comes near him, he starts screaming and carrying on."

But mothers voice their greatest concern about a child's hospital experience when they ask: "What has this done to his growing up?" And they may sadly add, "He was doing so nicely. Now he's . . . he's just not coping anymore."

Interference with growth

What indeed does hospitalization do to the child's process of growing up? An adult can take 6 months out of his life to recover from an overwhelming experience and come back to where he was before, but can a child? What happens to the normal psychological growth processes while the child's energies are so diverted?

The preschool years are those during which the psychological growth of the child is proceeding by giant steps. This is the period when the child is discovering and practicing new ways to cope with the world, laying the groundwork crucial to his later successful adaptation. At this busiest of times the child cannot divert his energies to dealing with an overwhelming emotional experience and still achieve this complex psychological growth at a normal rate. Therefore, *even brief hospitalization carries with it significant psychological hazard, especially for the child under 4 years of age.*

Why is this so? What is the nature of the stress the child experiences? How does he react to that stress and what do his reactions mean? The answers to these questions hold the clues to rational prevention and alleviation of damaging reactions.

To begin with, stress *per se* is not the unmitigated villain. Some stress is essential to normal psychological growth: the right amount at the right time stimulates the maturation of the child. Indeed, the child who is protected from normal stress by indulgent or excessively protective parents will often remain adaptively immature.[4]

Whether a stress is overwhelming or conducive to growth depends upon the present adaptive capacity of the child. In many instances, hospitalizing the preschool child subjects him to a particular kind of stress, *separation* from his mother, for which he is psychologically unready. His limited adaptive capacity is then overwhelmed by the experience.

To understand this, it is necessary to look at the normal way in which a child psychologically separates from his mother. The achievement of such separation by the growing child is the end point of a gradual process, a process that cannot be abruptly accelerated.

The infant begins by experiencing the protective care of his mother as a kind of fusion. Step by step he becomes aware of his physical separateness, of his mother's independent comings and goings. Only much later does he understand, and concede, her independence from him. In this gradual way he comes to appreciate his separate individuality.

Each step in this process brings the child a wider perception of reality, and, largely because of his helplessness, a measure of anxiety. That anxiety, kept to tolerable proportions by his mother's protective presence, is ultimately mastered by learning to cope with reality. Thus, for the child today's crisis becomes tomorrow's exploit, and the concerns of yesterday come to seem like foolish apprehensions.

Hospitalizing the preschool child violates this process. The degree of separation involved is usually beyond the adaptive capacity of the child. As though this were not enough, the child is at the same time subjected to other stresses. He is likely to be in pain, which may well be the worst feeling he has ever known, and his mother, who usually takes away un-

Rooming in at the Children's Hospital, Washington, D.C., a mother helps keep her child's mind off the unpleasantness of hospital life through the comforting security of her presence.

pleasant feelings, is not there to help him. He is surrounded by strange people whose clothes are all alike, but whose faces are somehow different—people who stay a while and then go away. Sometimes they return, sometimes they do not. Some of them wear masks, like bad guys on TV. They smile, then do things that hurt. There are giant machines that tilt and whirr and descend on you. Things smell funny. Any hour of the day or night somewhere children are crying.

For the child under 4 years of age, the hospital is a strange and frightening world, and he is alone in it.

Protest, despair, denial

How does the child react to all this strangeness and stress? James Robertson, in his classic little book, "Young Children in Hospitals",[5] describes three stages of the child's reaction. With eloquent parsimony he calls these stages *protest*, *despair*, and *denial*.

The first reaction of the aggrieved child is protest. He cries, shakes his crib, throws himself about. He will have nothing to do with the nurses. He wants his mother back, and *now*. He listens carefully to each approaching step, until he knows it is not his mother returning: then he resumes his protest. Gradually, however, as his disappointments accumulate, his protest loses its intensity. He is beginning to despair.

Acknowledging his loss, he has begun to mourn. He withdraws, becomes inert and apathetic. When the nurses make overtures to him, he does not respond. His cry is intermittent, and its character has changed. It has become a monotonous, wailing lament.

Sometimes, when despair sets in, busy nurses, noting only that the child has stopped shaking his crib and screaming, say he is "settling in, becoming adjusted to the ward". They may welcome the respite. They do not always recognize the onset of hopelessness or realize that despair is burying itself within the child.

When the child's mother visits him, his behavior changes. He becomes angry and distressed. He clings to his mother, and when it comes time for her to leave, he protests again with all the vigor he once displayed. Because the mother's visits seem to make him more unhappy, the nurses sometimes feel it would be better if the mother did not come to the hospital.

Some children whose hospital stay is prolonged eventually pass from despair to denial. They regain interest in their surroundings, respond to the nurses, begin to smile again. When a mother visits, the child may seem barely to recognize her, and when she leaves he may not protest. It is as though this most crucial of relationships has lost all meaning for him. Sometimes, when the child leaves the hospital for home, he clings to the nurse and treats his mother as though she were the stranger.

When such a child returns home, the inner conflict and anxiety, temporarily managed, come to the surface once more. He becomes aggressive and reacts to the mother as one who abandoned him. He has nightmares and shows phobic reactions toward objects that remind him of the hospital. Until the child has worked through these feelings, he cannot resume his psychological growing up from the point at which he left off when he entered the hospital.

Many a mother, intuitively recognizing her child's needs for special handling at this time, may respond to the child's distress with sympathetic concern. Sometimes her concern undermines her judgment and she establishes a pattern of overprotectiveness, failing to recognize when protectiveness is inappropriate. In my experience as a child psychiatrist, I have seen a number of women with adaptively immature children whose infantilization began with the mother's reaction to the child's reaction to hospitalization.

Because the symptoms of emotional disturbance often do not appear until the child has returned home, hospital staff members are sometimes unaware of their frequency and magnitude. It is important therefore to reiterate: ***hospitalizing the preschool child exposes him to separation and other stresses that are frequently beyond his adaptive capacity, and may interfere with his subsequent psychological growth.***

Prevention and alleviation

What can be done then to prevent or minimize the psychological hazards of hospitalization for young children? Two approaches are necessary: (1) to *avoid* hospitalizing children whenever possible; and (2) to *redesign* hospital child care practices to reduce the stress of the child's hospital stay as much as possible.

For the child under 4, avoiding hospitalization is the preferred course and one that may be more possible than it may seem at first thought. Children are sometimes brought into hospitals to clarify diagnoses through observation and laboratory tests that might, with a little ingenuity and inconvenience, be managed in the physician's office or in the hospital's outpatient clinic. The practice of some insurance plans of paying for tests when done on a hospitalized patient, but not for the same tests when done on an outpatient, may be a factor in promoting admissions of this kind.

In considering whether to hospitalize a child, the physician has a responsibility to weigh the advantages against the disadvantages. But like other experts in these days of specialization, the physician tends to focus his attention on his particular area of competence, the physical health of the child. Thus, he may fail to give proper weight to the possible psychological consequences of hospitalization—a major hazard for children under 4. The child's parents, of course, have to rely on the physician's judgments.

If parents and physicians were willing to make the effort not to hospitalize children, many sick children might be nursed effectively at home. Much hospital equipment is portable: beds, croup tents, intravenous stands. With a visiting nurse as a daily consultant, the mother may be able to care for the child herself. Homemaker services—if available—might be called in to assume some of the household burdens while the mother is so occupied. Expensive? Perhaps, but surely not more than the $50 to $75 a day it now costs to keep a child in a hospital. This assumes, of course, that these supporting services exist in the locality in sufficient quantity to be available when needed. In some areas they do not.

When hospitalization cannot be prevented, can the child's stay in the hospital be shortened? There is a tendency to keep the child one more day, "just to be sure," or over the weekend because "administration has gone home." If physicians and hospital staff members recognized the urgency of getting the child home as soon as is consistent with prudent care, they could, I am sure, reduce the length of hospital stay for many children.

For the child who must stay in a hospital for more than a day or two, steps should be taken to reduce the stress he undergoes while there. For the child under 4, this means minimizing the separation from his family.

The most effective way to do this is to admit the mother along with the child. There is nothing particularly new about this idea.[1, 5] Indeed, in less developed societies it is the rule,[6] and people view the western practice of separating the sick child from his mother as bordering on the barbarous.

The technique of such double admission, sometimes called rooming-in, involves the provision of a cot and living arrangements for the mother near her child, and encouraging her to participate in his care. While such an arrangement may or may not complicate *patient care*, there is considerable evidence that it improves *child care*.

Despite its demonstrated value,[5] rooming-in has not become popular among the staff and administrators of hospitals. Those who resist it argue that the mothers are more bother than help, that they are anxious about their children and find it hard to participate in their care. Failing to recognize a child's protest as a psychological necessity, the resisters point out that the children's ward is quieter when the mothers are not there. Even so, increased psychological risk to the child is too high a price to pay for peace on the ward.

The practice of allowing mothers liberal or unrestricted visiting is another useful way to reduce the impact of separation of the hospitalized child.[1] Such visits may upset the child, but when they do they are *uncovering* his distress, not *creating* it. Thus, they help the child discharge some of his accumulated tension. More important, perhaps, by reducing the degree of separation of mother and child, they provide the child with evidence that he has not been totally abandoned.

Although the practices of rooming-in and unrestricted visiting have proven of value in reducing children's reactions to hospitalization, it is my impression that such policies are uncommon in hospitals in this country outside of university settings.

The resistance of hospitals to instituting such measures arises in part from a failure to understand the situation. After all, it is said, entering a hospital is always a kind of disaster and some degree of emotional upset is probably inevitable. Because physicians and nurses see a lot of tragedy in families, they may lose sight of the significance of a traumatic experience to an individual child. Living as they do with the necessity of watching children die, they

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may, understandably, not be moved to action by the psychological problems of the briefly ill child. Moreover, such a child soon disappears from their sight. Unless the mother complains, physicians and nurses may easily assume that all became normal again as soon as the child went home.

For some or all of these reasons, children are not being protected from the psychological risks of hospitalization. Recently, however, a group has been formed that is reawakening concern over this problem. Called the American Association for Child Care in Hospitals, it grew out of a meeting of child development specialists held at the Boston Children's Hospital in 1965 and was formally organized the following year to include representatives of various professions concerned with the health and well-being of children.[2] Its goal is to advance family-centered pediatric hospital care.

Another aspect of this problem was illumined by Robert S. Mendelsohn, M.D., formerly director of the American Academy of Pediatrics' Consultation Service to Project Head Start, when he asked the compelling question: Could parents sue a hospital and doctor for psychological damage to the child?[7]

When the child goes home

Even when appropriate preventive measures are taken to lessen the psychological effects of hospitalization on children, the experience will prove overwhelming to some children. Disturbances will occur. What can the physician do to help the mother cope with these difficulties in a way that will restore the child to normal psychological growth?

When the child goes home, he is driven by two principal needs. The first is to discharge his accumulated affect, to desensitize his trauma. So, he complains, blames, fusses, demands, and expresses fear that his mother may abandon him again. The second need is to be "filled up" with the kind of closeness he once had with his mother. He needs to have a period of excessive maternal gratification to make up for the period of loss, to reestablish his normal degree of dependency on his mother and to restore his trust in her.

Intuitive mothers often recognize the child's need for additional closeness and try to meet it. Yet they wonder if they really ought to be feeding the child again, or allowing him to cling. Their uncertainty makes them anxious. Their anxiety sometimes misleads them. They may feed the child but scold him as they do so, which is neither "filling him up" nor getting him to assume his normal responsibilities again. Or their anxiety may lead them to blame the hospital nurses or themselves, which in no way improves their judgment with respect to dealing with the child.

A cheerful visitor helps make lunch a happy affair for a group of children who are convalescing in a hospital ward.

The physician can inquire, listen, and advise, and an important benefit will be a reduction in the mother's anxiety. By talking to the physician about the behavior that worries her, and by learning from him that such symptoms are common after a child's visit to a hospital, the mother becomes more relaxed. With her anxiety relieved, her judgment about the child is restored, and the prospects of her anxiety being converted into the kind of excessive solicitude that leads to continued infantilization of her child are reduced.

The doctor says something like: "Don't worry if he's back to baby ways for a little while. Feed him, spend time with him, indulge him a little. In 10 days we'll start worrying about helping him grow up again." And if the child is keeping the mother awake, the physician can prescribe a little mild sedation for a few nights. Direct advice reassures, and the physician should not hesitate to dispense it.

Growing up again

The second phase of post-hospital care is concerned with getting the child back to the business of growing up.

Most of the child's symptoms are directly traceable to a pervasive separation anxiety. He clings to his mother and will not let her out of his sight. He cannot go to sleep if she is not there or out to play unless she remains in sight by the window. Clearly, he is afraid that he will be abandoned again.

Separation anxiety may be *alleviated* by not separating, but so handled it does not become more manageable in the future. Separation anxiety is *mastered* by experiences of successful separation—that is, experiences of separation that are long enough to produce a degree of anxiety in the child, but not so long as to overwhelm the child's present adaptive capacity.

Therefore, once the child is reasonably "filled up" again with maternal protectiveness, the mother, if she understands what is required, begins to impose brief separations upon him. She makes a point of going out for half an hour, perhaps in the early evening when her husband can babysit. The child protests her going and is tearful on her return. She goes again, and again the child protests. On the third occasion, however, his protests are less vehement. This time she stays away a little longer or she may leave him with a person less familiar to him—a neighbor perhaps. Thus, gradually increasing her expectations, she leads the child back to the point of adaptability he had reached before he went to the hospital.

Through this purposeful imposition of separation, the mother is engaging the child in a process of desensitization and relearning. Each time she leaves and returns, the child fears he is going to be abandoned but discovers he is not. When the mother returns he learns (through experience, the principal way very young children learn) that abandonment and overwhelming anxiety are not inevitable consequences of separation. By mastering small doses of separation, he stretches his capacity for functioning independently. Gradually his lost trust is restored.

The physician can help the mother with this process. He does so primarily by supporting her, by dissipating her anxiety, by reassuring her, by letting her bolster her uncertain efforts with his authority, and by helping her decide the specific moves she will make. He continues to support her until a measure of success convinces her she is on the right track.

Without such help, there is danger that the mother will gravitate into a cycle of action and reaction that impedes the child's growth. For example, the mother may continue to defer to the child's apprehensions and meet his infantile expectations until, anxious about his persistent immaturity and wearied by his demands, she loses patience and suddenly explodes with excessive expectations. The child cannot meet these expectations, and he reacts with tears and further regression. Filled with remorse, the mother "makes it up to him" by renewed indulgence. She is back where she started and the cycle begins again.

The outcome of such a cycle can be a serious delay in the adaptive maturation of the child. In a few years there may be such a noticeable discrepency between the child's capacity and the expectations of his world that psychiatric help is needed to restore a growth-inducing mother-child relationship.

It would be better, of course, if children never had to enter a hospital, but they do, and the reality must be accepted and coped with. Patterns of in-hospital care need reappraising *now* to preserve the emotional as well as the physical health of the child. Even so, prevention remains the superior remedy.

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Even if science shows us the way to feed billions more—as indeed it may—we still would not have mastered the population problem. The full solution depends also on society's ability to meet man's higher, nonmaterial needs, to offer every child an opportunity to achieve in life more than mere existence—a chance to *live* as well as to survive . . . .

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THE EFFECT OF BLACK HISTORY ON AN INTERRACIAL GROUP OF CHILDREN

BELLE LIKOVER

As racial tensions continue to escalate and the schism between black and white deepens, professional workers who serve young children have become acutely aware of their responsibility for dealing with racial prejudice. Teachers, social workers, day care workers, nursery school personnel, and religious leaders are daily grappling with the problem of how to become more effective in developing respect and understanding between persons of different races.

Most professional people have long been familiar with the axiom that the transmission of prejudice can best be blocked in a young child whose attitudes and behavior are still flexible. However, the field of human relations has produced little research on how to overcome prejudice.

What has been lacking in the American consciousness at all age levels is the history of the black people and the effect on them of historical and economic events. Schools have largely neglected the degradation and brutality of slavery and subsequent exploitation of blacks and also the achievements of blacks and their contributions to the productivity, growth, and thought of this country. With few exceptions, textbooks have ignored blacks completely or presented only racist stereotypes.

Currently the black community is pushing for courses in black history in the public schools to consolidate the feelings of black pride, dignity, identity, and solidarity. Knowledge of black history is equally important in the white community; overcoming white racism requires a factual basis for understanding why opportunity has been denied to the blacks.

This was our rationale at the Jewish Community Center of Cleveland when in 1969 we undertook a demonstration study of the effect of the introduction of black history on behavior of children in an interracial group at Playland, a summer day camp operated by the agency for children who have completed kindergarten or first grade. Herman A. Eigen, executive director of the Jewish Community Center, encouraged us to do the study, which was made possible by a grant from the Frances W. and H. Jack Lang Foundation.

Marvin Rosenberg of the School of Applied Social Sciences at Case Western Reserve University gave us invaluable assistance in designing the study. We relied heavily on a theoretical proposition that there is an integral connection between cognitive and affective domains in human development.[1, 2] The cognitive domain deals with knowledge and information, the affective domain with feelings and emotions. The theory suggests that all behavior has both cognitive and affective components, which cannot be separated.

Because of their essential interdependence, both the cognitive and the affective components of human relations programs must have equal emphasis if changes in attitudes and behavior are to be achieved. However, most attempts to improve race relations have dealt almost exclusively with affective domain. Also, much of the material developed for children in this field emphasizes the biological and aspirational similarities of all races and deemphasizes the differences between the races.

We therefore included a cognitive structure in our program, based on historical facts rather than myths, stereotypes, or wishful thinking. We assumed that if both the affective and cognitive components of the program received equal emphasis, we would be changing attitudes and that these changes could be observed in the interaction between black children and white children.

Basically we were concerned with observing behavior rather than measuring attitudes. We looked at the behavior of white children and black children toward each other as the measure of understanding and acceptance.

The setting

The study was carried on within the regular framework of the Playland program. We knew from Mary Ellen Goodman's classic work, "Race Awareness in Young Children,"[3] that racially related value systems and the onset of bigotry are to be found in children as young as 4 years. Thus the 6- and 7-year-old children in our camp were old enough to be aware of race but still young enough to be influenced by new information and experiences.

The children who attended Playland came from the population served by the agency—predominately middle-class, white, Jewish, suburban families—and generally included only a few black children. In 1969, however, we actively sought children from black families living in the communities adjacent to the center. We explained to the black parents that one of the goals of Playland was to help children accept racial differences and we gave seven partial scholarships to increase the number of black children in attendance. In this way the day camp enrolled enough black children whose socioeconomic status was comparable to that of the white children for a valid study.

Neither the children, black or white—nor their families—were aware of being in an experimental program. Such information was carefully concealed to avoid the "Hawthorne effect,"[4] a distortion of findings that occurs when subjects, knowing that they are part of an experiment, give answers that they think are expected instead of expressing their own convictions.

Since I was director of both the day camp and the research project, the study group had to be limited to a size that would permit me to carry out my responsibilities in both capacities. The Playland program had separate groups for girls and boys, and we decided to confine the study to two matched groups of girls—13 in each group. The study was conducted over a period of 4 weeks, during which the children attended Playland 4 hours a day for 5 days a week.

In selecting the experimental and control groups, intake material on all the girls registered in the program was carefully examined. Children from broken homes and children with physical or emotional handicaps were excluded to make sure that results would not be influenced by differences in personality or individual frustrations.

We selected 26 girls—16 white and 10 black—for the study. They were assigned either to the experimental group or to the control group by a random assignment stratified for race and school grade level. The racial composition of the groups was identical; in each group of 13 girls, five were black and eight were white. The groups were also identical in the girls' school levels; in each group eight girls had completed kindergarten and five had completed the first grade. The number of whites and blacks who had completed kindergarten or the first grade were identical in both groups.

A college student with some experience in working with children was selected as counselor for each group. These girls were given an orientation about the purpose and design of the study to insure their understanding of the difference in programing for the two groups. High school girls who volunteered as junior counselors were given the same orientation and their roles were clearly defined. All counselors received consistent supervision from the camp director.

The only additional staff member hired for the study was a nonparticipant observer. Combined with experience as a nursery school teacher, day care center director, and Job Corps counselor, she had

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sensitivity, insight into children's behavior, and interviewing skills. She divided her time between the experimental and control groups in order to observe patterns of interaction and behavior among the girls. Introduced to the campers and parents as the assistant to the program director, she was completely accepted as a staff member. Although she would chat informally with the children, she functioned strictly as an observer: she did not in any way interfere with or direct any program or activity and she did not write her observations in front of the children.

Program

Playland offered the usual range of day camp activities—games, music, dancing, creative arts, swimming, and the like. The program during the first week was the same for all the children. The first week also served as a pretest period for the initial observation of the behavior of all the girls in the control and experimental groups toward girls of another race.

The girls in the two study groups were separated as completely as possible in the camp settings: except for swimming, they did not engage in joint activities.

One of the goals of the Jewish Community Center—the transmission of Jewish culture, history, and ethical values—was used to set the stage for the teaching of black history and to reinforce the basic concepts of tolerance. During the first week of camp the program theme was Jewish holidays around the year. Each group selected a different holiday to explore. The experimental group chose Passover, from which the girls learned of the oppression and slavery of the Jews in the Biblical period and of the concepts of justice and equality of all men. With this background the girls were later able to compare and contrast the slavery of the Jews with the slavery of blacks in this country. It helped them translate the concept of justice from history to today's world.

Black history was introduced to the girls in the experimental group at the beginning of the second week through many program forms, including stories, dance, song, art, and discussion. The counselor, with help from the camp director, translated the historical material to a level appropriate for 6- and 7-year-old girls. Using the camp's general theme for the second week—independence and freedom—the experimental group concentrated its attention on the struggle of blacks for freedom.

The study began with the period of slavery and continued to the present. One of the counselors described one day's events:

> With the aid of a puppet who represented Thomas Smith, a Negro slave, I told the "real and true" story to the girls of the black people's struggle for freedom in the U.S.A. from the time of the first shipment of Africans to southern shores to the present, concentrating on the years of slavery and hardship. The girls reacted most violently to the account of certain physical and emotional hardships that the slaves suffered—the hot sun, dirty small cramped living conditions, the separation of father from mother and children. Terry (white) asked incredulously, "You mean children were taken away from their mothers?"
>
> Kelly (also white) asked, "And they weren't allowed to marry who they wanted to?"
>
> The nonverbal expressions of shock on the part of the white girls were unmistakable.
>
> I emphasized the fact that in 1776 "not everyone was really free" and just what this meant. I also mentioned that until a few years ago blacks and whites were not allowed to eat in the same restaurants or use the same bathrooms in the South—a fact which both surprised and shocked the girls.
>
> Throughout the discussion most of the black girls were quiet and seemed almost uncomfortable, with the exception of Anne, who was quietly absorbed and who really bloomed. . . .
>
> Nancy (black) had quite a lot to tell about her next-door neighbor who tried to buy a house and couldn't because she was black. Terry said with feeling, "Just because you have different color skin doesn't mean you are different."

Later each girl in the experimental group made a slave puppet. The group wrote a puppet show that included among other songs, "We Shall Overcome." In developing the show, the girls discussed the meaning of the song with their counselor.

During the third week of camp the girls explored the contributions that blacks have made to American society under the program theme, great Americans. Biographical material about Negro heroes was presented. One of the heroes was Martin Luther King, Jr.—a man most of the girls already knew about. Discussion of his life gave the group an opportunity to reexamine the kind of discrimination he fought against as well as his philosophy of cooperation between black and white.

The counselor chose another hero, John Henry, to illustrate the contribution of black labor to the building of America. She later reported:

> I used a beautifully illustrated story book about John Henry that was completely captivating.[5] Anne (black) said, "He was a very brave man."
>
> Linda (black) told a story about her grandfather who had worked very hard and died of a stroke. Ellie (white) reminded

> us that whereas John Henry had died, Martin Luther King had been killed. "Assassinated," said Linda.
>
> The girls learned the song "John Henry." Nancy (black) told the girls which words to stress and, without any coaching from me, the girls then sang the song with a great deal of feeling.

During the first week the control group studied Purim, another Jewish holiday with an emphasis on freedom. However, instead of following it up with the material from Negro history, this group's next unit theme was freedom of speech. In the third week the control group learned about Johnny Appleseed and other farmers as American heroes.

During the second and third weeks in the control group, discussions of the girls' feelings about race were stimulated by the introduction of two picture books, "In Henry's Backyard" [6] and "Your Skin and Mine." [7] Both books present classic anthropological concepts about race in a form that elementary school children understand. This material was also used in the experimental group, but none of the program material developed for the experimental group was used in the control group.

The effects

We used three measurements to determine the effectiveness of the experimental program:

1. *An interaction scale.* Previous experience with interracial groups from a middle-class socioeconomic level taught us not to expect open hostility. Such children usually show their prejudice through avoidance—reluctance to sit next to a child of another race, to select her as a partner, or to initiate a conversation with her.

Counselors and junior counselors were instructed never to direct children toward partners. Thus each child was allowed to make her own selection of friends at all times. Counselors deliberately provided many opportunities for observing the children's preferences by asking the girls to pair off as they moved from one part of the building to another and as they changed activities.

At the end of the first and fourth weeks of camp, ratings were made for each child on a five-point racial interaction scale. (See col. 2.) The counselors and the nonparticipant observer rated each child separately.

2. *Daily process records* kept by both the counselors and the nonparticipant observer. These records presented a rich story of each child's behavior toward the children of the opposite race.

3. *Concepts that the children expressed at home.* At the conclusion of the 4 weeks the mothers of all the girls from both the experimental and control groups were interviewed by either the nonparticipant observer or the camp director. The mothers were asked such questions as: What did your child discuss at home about Playland? What was her reaction to her experience? If these open-ended questions did not evoke a relevant response, the mother was asked if her daughter mentioned anything about race. At the conclusion of the interview, the mother was informed of the experiment and asked her reaction to it.

At the end of the first week of camp, a distinct color line was obvious in both the experimental and the control groups. With few exceptions the black children stayed together. They reached out to the counselors rather than to the white girls, intuitively feeling that this was "safe" for them. Although none of the white girls showed any hostility, few of them made any effort to reach out to the black girls.

There was no tension between the whites and the blacks in either group. All the children worked on common projects without friction. However, interaction between the races was minimal: basically an ignore-but-accept pattern developed.

After black history was introduced in the experimental group, a new pattern of interaction began to

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RACIAL INTERACTION SCALE

Positive behavior toward opposite race	5	4	3	2	1
Sits next to					
Picks for partner					
Engages in conversation with					
Shares materials with					
Holds hands with					

Scoring: 5—repeatedly, 4—frequently, 3—sometimes, 2—rarely, 1—never.

This scale was originally planned to measure both positive and negative aspects of the children's behavior but the negative measures were discarded because of the absence of overt hostility.

evolve. The black girls no longer relied on the counselors for support but began confidently to reach out to the white girls. The white girls also made overtures in an easy natural way and developed friendships with the blacks.

The following illustrative vignettes are from the reports of the counselors and the nonparticipant observer.

> There was a definite show of affection between Lollie (black) and Betty (white) . . . None of the black children were forced by exclusion to be partners with one another . . . Kate (black) once again asked a white girl to be her partner . . . Linda (black) walked down to swimming with her arms comfortably thrown over Kelly's (white) and Ellie's (white) shoulders.
>
> In the locker room Terry (white) for the first time picked Anne (black) for a partner and told her that she was pretty and cute—quite a change from Terry's reluctance to refer to Anne by name during the first week . . . Agnes (white) and Linda (black) argued over who would be Nancy's (black) partner . . . Nancy looked up and said with great joy, "They both love me!" She settled it by counting out.
>
> Ellie asked Anne very seriously, "Does it bother you when we talk about Negroes?" Anne answered, "It's all right. It doesn't bother me at all. I don't mind a bit."

As this pattern of easy atmosphere and mutual respect developed in the experimental group, the pattern in the control group changed little. Except for one black girl who consistently sought out the white girls, the black girls tended to cluster together and continued to look to the counselor and junior counselor for security. Although there was no open rejection and all girls participated in activities, friendships developed mainly between white and white, and black and black. For the most part only superficial relationships were formed between black and white.

The difference in the two groups was corroborated by the staff members' ratings of the girls on the racial interaction scale. (See p. 180.) The overall ratings by the counselors and the nonparticipant observer showed basically the same picture, with some minor variations. The counselors showed slightly higher ratings than the observer at the end of the first week, however. This may be explained by the fact that the observer, who divided her time between the two groups, did not see as many instances of interaction as the counselors.

A racial interaction index (see p. 182) was obtained for each group by averaging the ratings of all the items on the interaction scale for all the girls in the group. This index showed that interaction had increased greatly in the experimental group after 4 weeks. Furthermore, examination of the individual scores of the girls showed that everyone in the experimental group increased her rate of interaction substantially. In the control group the individual increases in interaction were minimal.

Interviews with mothers

Perhaps the most dramatic evidence of the change in behavior in the experimental group was obtained through interviews with mothers, who reported the kind of information about race that the girls had brought home from Playland. At the end of the interview, each mother was asked not to discuss the purpose of the interview with anyone until all interviews were completed. In all cases but one, we believe that our request was honored and that mothers were not primed for our questions by other mothers.

All of the black girls in the experimental group had repeated at home the black history they had learned at day camp and had discussed the stories with members of their families. Such reactions could, of course, be expected. More significant perhaps was the poignant appreciation expressed by some of the mothers for the self-confidence and self-respect their children developed.

> Mrs. M. said that Nancy came to camp aware that she was different. This child had experienced many fears and hurts at school because of her color. Her mother said that before the end of Nancy's camp experience, these fears began to disappear. Even during camp, she came home relaxed and at ease. One day she announced, "I am special." When her mother asked why, Nancy said, "Because I'm black."

Of the eight white children in experimental group, six told their families the stories of slavery, discrimination, Martin Luther King, or John Henry. Most of the girls gave their impressions with great clarity and feeling. They shared their anguish over the effect of discrimination in various ways.

> One child said, "Do you know that Negroes at one time were forced to sit at the back of the bus?" . . . Several girls related their sadness about the treatment of slaves, especially the splitting up of families . . . When Ellie said to her mother: "I wonder how Anne feels when we talk about Negro people," her mother suggested that she ask Anne . . .
>
> Elaine's mother asked her, "What's different about your Negro friends at Playland?" Elaine answered, "There is nothing different about them, they're the same." Elaine explained to her mother the difference between the Negro slaves in America

and the Jewish slaves in Egypt . . . Betty told her mother that Negroes still do not have their freedom.

Two white girls from the experimental group did not mention at home what they had learned at Playland regarding race, although both girls seemed to have understood the stories and both had made friends with black girls at day camp. For one of these girls, the lack of discussion may have been related to the general lack of communication in her home. The family of the other white girl openly expressed racial prejudice.

The interviews with the mothers of the girls in the control group told a substantially different story. Of the five black girls, four discussed some of the anthropological information at home. They were impressed by the story "In Henry's Backyard."[6] However, none of the white girls was sufficiently moved by this story to repeat it at home. Three girls made no mention of race, and their parents were unaware that any black children had been included in the camp program. Five of the white girls made derogatory remarks about blacks.

During the interviews parents of girls in both experimental and control groups made statements showing racial prejudice in about the same frequency. Similarly mothers in both groups made about the same number of favorable statements about the project. Therefore the differences in the attitudes of the children between the groups could not be attributed to differences in home atmosphere. A number of the white mothers from the control group expressed regret that their daughters had not participated in the experimental program.

Conclusions

The evidence indicates that the introduction of black history in the experimental group made a substantial difference in the interaction between the black girls and the white girls. We believe that paying equal attention to the emotional and cognitive components in our program led to a change in the girls' behavior patterns.

Certainly, a great deal more research is needed: the hypothesis has to be tested in different settings. Is this method applicable in a more formal setting such as a school that has larger classes and is multiethnic in composition? How could it be applied to other socioeconomic groups, other age groups, and other settings where there is evidence of open hostility? Can it be used in coeducational groups?

RACIAL INTERACTION INDEX

Group and rater	1st week	4th week
Experimental group:		
Counselor	2.45	4.41
Nonparticipant observer	1.88	4.58
Control group:		
Counselor	2.43	2.75
Nonparticipant observer	1.80	3.00

The increased interaction between the black girls and the white girls is expressed in this index, in which each figure represents an average of the ratings for all 13 girls in each group on all items in the racial interaction scale (see p. 180).

Some steps are already being taken to find answers to these questions. The study is currently being used by the Cleveland Heights-University Heights, Ohio, school system in curriculum planning and in-service training.

Our study was an attempt on a minimal budget to apply scientific methods to an existing program. Although the experiment was small in scope, the methods used can be replicated and adapted to other settings, age groups, ethnic groups, and socioeconomic groups. The information derived can immediately be translated into practice. The positive results may spur others on to report on their experiences in dealing with the vital issue of how to eliminate prejudice.

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REUNITING CHILDREN and PARENTS through casework and group work

HANNI B. EDINGER

In 1968 St. Christopher's School in Westchester County, New York, undertook an experimental program of intensive work with a group of parents of children in foster care. The purpose was to explore whether a combination of individual casework and group work might lead to improved parent-child relationships and speed the return of the children to their families. If after a year's trial the effort proved effective, then the agency expected to incorporate this type of service into its regular program. The costs of the experiment were met through a private gift to the agency and a grant from the Federation of Protestant Welfare Agencies.

St. Christopher's School is a voluntary, nonprofit, interracial, and nonsectarian agency that places and serves emotionally disturbed and neglected children in both institutional and foster family care. The children it serves come from New York City and surrounding counties.

Until the Parent Group Project was begun, the agency had relied almost exclusively on individual casework with children as its method of treatment. Because of insufficient funds and staff time, the staff was not seeing the parents on any regular basis. Moreover, the caseworkers frequently overidentified with the children, a tendency among staff members in child-caring agencies that makes parents feel isolated and rejected.

The Parent Group Project got underway at the beginning of 1968 and ended in March 1969 when funds for the experimental program were exhausted. It provided a selected group of parents with casework service through biweekly visits from a caseworker to their homes and with biweekly child-focused group discussions conducted by a psychiatrist.

Family casework agencies have for several years been providing group therapy to some of their clients "not primarily because it may save time or money or enable an agency to reach more people, but because it represents a treatment approach that has unique advantages for certain clients."[1] Some residential centers for children have also been working with groups of parents of children in their care, but reports of these efforts are few.[1-4] Therefore, it seems important to report the experience at the St. Christopher's School.

I served as the parent group caseworker for the duration of the project. My responsibilities included giving direct casework service to the individual parents; providing liaison between the project and the children's caseworkers; being the recorder and a participant observer at the group meetings; and making periodic reports to the agency's board and staff on the progress of the project. The psychiatrist, Dr. Harvey Rosenblatt, led the group meetings and conferred with me for an hour each week. The caseworkers for the children, both in the institutional and the foster family home departments, helped select the parents for the project. They were kept informed of every step in the project's planning and progress through informal consultations with me and through meetings of all staff members connected with the project.

Selection of participants

In selecting potential participants, the caseworkers were asked to use the following criteria:

1. Parents whose involvement in the group could be expected to result in the child's returning home sooner than otherwise.

2. Parents in intact families who were not receiving public assistance.

3. Parents with children who were functioning moderately well at home and in the community.

4. Parents who had shown some ambivalence about placing their child away from home and had maintained regular contact with the child.

5. Parents who asked to have their child returned to them although the child had been removed from home by a court order.

Parents who were psychotic, had psychopathic personalities (drug addicts, criminal records, alcoholics), or were chronically ill were ruled out, as the chances of returning their child home seemed remote.

These criteria and restrictions were established to maximize the chances of the project's success. Some compromises had to be made, however. For instance, it proved to be impossible to find enough intact, self-supporting families to form a group of the desired size. Therefore, some divorced and unwed mothers, including two recipients of public assistance, were included. Geographic considerations also had to be taken into account, for although the children in care came from the entire New York City metropolitan area, the parents in the group project had to be willing and able to attend meetings at the agency's Manhattan office.

Eleven parents were originally selected for the project. The agency's director sent them letters of invitation to a new service "to provide extra time to discuss problems and plans in connection with the placement of your children." All but one of these parents accepted the invitation. The parent group caseworker then interviewed them either at their homes or in the agency's Manhattan office. The purposes of these interviews were:

1. To elicit information on—

- Their attitude toward the agency.
- Whether they felt there had been a change for better or worse in the way their child related to them since his placement away from home.
- Whether they could express their feelings about their children in a group of parents.

2. To explain the agency's reasons for establishing the project, what it would include, its experimental nature, and why they had been invited to participate. The parents were told that—

- The agency expected the parents' exchange of information and experiences in the group discussions to help the staff as well as the parents learn how to deal with their children's problems.
- Casework treatment would be offered as part of the project.
- They had been selected as persons who might like to participate in the learning experience offered and who might help the agency decide whether this type of service should become a part of the agency's regular program.

3. To find out what day and time would be most convenient for the group meetings.

The group

Seven of the ten parents interviewed actually became participants in the group, and six of these remained with it until the end of the project. Three additional parents joined the group after the project got underway. Thus the group had ten members in all; six attended the meetings fairly regularly.

The participants ranged in age from the late twenties to the middle fifties. They included five Caucasians, four Negroes, and one Puerto Rican. Although the project took place during a period of increasing polarization of the races and racial problems were discussed at the meetings, the group showed no signs of racial antagonism.

Hanni B. Edinger has been employed during the past year as a caseworker and parent group worker at the Clear View School of Westchester, Dobbs Ferry, N.Y. Previously she spent a year at the St. Christopher School in Dobbs Ferry, working on the project described here. With a master's degree from the George Warren Brown School of Social Work, Washington University, St. Louis, Mo., she has also worked as a school social worker in St. Louis.

We had hoped to involve fathers as well as mothers in the group, but because the meetings were held at 4 p.m. on weekdays, only one father attended more than a few meetings and he eventually dropped out because of a conflict with his work schedule. We found it impossible to set another meeting time because some of the mothers were afraid to go out at night and Saturday meetings were ruled out because of the psychiatrist's commitments.

Twenty-two group meetings, lasting an hour and a half each, were held from March 1968 to March 1969, with an average attendance of five participants. About the same number of casework interviews were held with each parent. To demonstrate the agency's wish to keep the parents involved, the time and place of the casework interviews were set at the parents' convenience: some were conducted in the parent's home, some near his (or her) place of employment during the lunch hour; some at the agency's Manhattan office after working hours.

The psychiatrist who led the group discussions let the structure of the meetings grow out of the parents' expectations, needs, and the kind of interaction that occurred. He imposed only one limitation—that the focus be kept on the child and his relationship to his parents.

Within this focus two patterns seemed to serve the purposes of the group best during the course of the year. In terms suggested by Scheidlinger [4] in his classification of attempts at influences that are not strictly in the clinical range of group psychotherapy, these patterns were:

The cognitive-informational focus—attention to the teaching of new information and the imparting of new attitudes.

During the early meetings the parents asked for all kinds of information. The staff members were astonished to find that parents whose children had been in the agency's care for several years knew little or nothing about the different services the agency offered or about its mode of operation. Parents whose children were in residential treatment were unaware of the existence of the foster care department and, conversely, those who had dealt only with foster home workers had no idea that the agency operated a residential treatment center.

After they learned about the agency's functions, parents began to ask questions concerning their children's symptoms and treatment: what is play therapy? what causes eneuresis? what is separation anxiety? why does my boy stutter? what does the institution do about homosexual activities?

This focus on information helped to relieve some of the parents' feelings of guilt for through it they learned that they could not be blamed for all that went wrong in their relationship with their children.

The relationship-experiential focus—the provision of an atmosphere conducive to the creation of a cohesive group that enables individuals to share their problems, dispel a sense of isolation, and receive emotional support.

This focus was probably of greater value to the parents than the first. It also brought repercussions on agency policy and practices.

The parents attested to its value for them in both the group meetings and the casework interviews. They told of how talking to others who had problems similar to their own had helped them overcome feelings of being alone with their problems and of having lost control of their children, so that they had become able to mobilize themselves into activity in their children's behalf.

The agency learned some things too. For example, one mother whose son was in residential care said, "I can't even buy him a pair of shoes anymore." All of the parents said that they felt intimidated by the professional workers who had taken over their parental functions but that they had not dared to question agency decisions. All seemed to have a nagging sense of having been labeled "bad" parents.

As the parents gained self-esteem, they began to challenge some agency decisions made for their children, especially those relating to visiting, telephoning, and letter writing between parents and child. They reproached the agency for not keeping them informed of their children's progress. They also supported each other in complaining about the children's caseworker, foster parents, or cottage houseparents. Because of the close working together of the parent group caseworker and the children's caseworkers, such frank discussions brought some changes in the agency's policy in regard to specific children and an eventual realization on the children's part that their parents could intervene in their behalf. For example, opportunities to make regular visits home were offered one child who had not been home for a year and a half because his mother had been afraid to ask his caseworker to allow him to visit her and the caseworker had been waiting for the mother to take the initiative. Similarly, arrangements were made for other parents to receive copies of their children's report cards, to telephone their children regularly, and to see them often.

The discussions brought to light some facts previously unknown to the agency staff about the way two children were being treated by their foster parents. As a result, the children were moved to more suitable foster homes.

The combined methods

In the views of parents and staff alike, the combination of casework services with a group experience enhanced the therapeutic value of the program. The parents' caseworker found that one parent's open discussion of his problem in the group would often stimulate another parent to unburden himself of a similar problem in the privacy of the casework interview. Conversely, the group meetings often became more productive for everyone after the caseworker encouraged a parent to share a problem with the group that the parent had revealed in a casework interview. Feelings of guilt were alleviated when secrets came to the surface. For example:

Miss M, an unmarried mother whose son had been in the agency's care for 5 years following treatment in a psychiatric hospital, first told the caseworker and later the group that she had resumed living with the boy's father but had concealed this fact from the boy, who did not know that the man was his father. After working through some of her ambivalent feelings about this relationship in the casework and group discussions, Miss M decided to tell her son who his father was. A helpful father-son relationship grew out of this revelation. Moreover, with Miss M's approval the father began to participate in her casework interviews and also in the parents' group discussions.

Mr. B's son had come into the agency's care because of chronic truancy. A self-made man who had high expectations of his children, Mr. B was troubled because his son "acted like a stranger" when he came home. Through the casework interviews Mr. B gained some understanding about the underlying cause of his son's behavior. Through the group discussions he learned to scale down his demands on his son and to recognize the boy's tentative attempts toward rapprochement with him. Eventually the boy, who at first had not been eager to go home for visits, requested that he be allowed to spend the summer at home.

Because some parents continued in the group after their children were returned to them, others had a chance to learn about the problems that can arise after children return home following a long separation from their parents. Casework services, both to the child and the parents, were also continued after a child's return home.

Miss B, who drank heavily, had had her three children removed from her home because of neglect. The prognosis for a successful reunion of this family had been considered poor. However, the children's caseworker decided that to include Miss B in the parents' group might be worth a try. Through the experience, Miss B gained so rapidly in self-esteem that she demanded the return of her children. After the family was reunited, Miss B remained in the group and participated actively in its discussions, telling, often humorously, of her trials and tribulations, and asking for the group's advice. Six months after her children returned home, she and the children were obviously doing well.

Assessment

When the Parent Group Project came to an end, positive changes could be reported for all participants and their children. Of the ten parents involved at one time or another, three had their children at home, and four parents were working out arrangements for their children's return within a few months. The mother of two boys expected one son home soon but no definite date had been set. Improvement in parent-child relationships was apparent in the other two families, although they were not yet ready for reunion.

One cannot say for sure whether these results might have occurred without the intervention of the parents' group. However, the responses of the children's caseworkers to a questionnaire suggest that the program was effective. These eight workers responded to the following questions:

1. Did the child whose parent or parents participated in the parent group refer to this during sessions with you?

Only one worker said that a child alluded specifically to the parents' group.

2. Do you believe a change occurred in parent-child relationships (positive, negative, or whatever) as a result of the parents' involvement in the group?

Seven workers saw positive changes. One of these commented: "Yes, the mother was better able to accept her son's growth and see that her need to overmother him was a deterrent to that growth." Another caseworker reported that a formerly undemonstrative mother had just told her daughter that she loved her and wanted her home—the first time she had ever done so.

3. Do you feel that a parent's participation in the group aided or hindered your treatment plan?

All eight caseworkers said they felt the program had aided their plan. For example, one said that participation "clarified some goals or forced movement where it might have taken longer or never come about for a variety of reasons: apathy of parents, apathy or anxiety of worker; also time limitation of workers and their own view of priorities."

4. Did any of the children you are treating whose parents were not participants ever mention the parents' group in any way?

Two such children were reported to have mentioned the parents' group.

The caseworkers were asked to add their criticisms, suggestions, and comments about the project. Six caseworkers said they thought all parents should be offered this kind of service. One commented about a specific case: "It gave this mother the opportunity to feel a part of the treatment team and important in her son's life, though separated from him."

Most of the parents who participated in the project also expressed positive feelings about the group and several said that they were looking forward to its resumption.

In conclusion

Thus the consensus among agency workers and parents seemed to be that the parents' program facilitated the return of children to their homes. An analysis of what occurred identifies the following helpful elements in the program:

1. *Mutual learning experience:*

- Parents learned about the agency operation and the purpose of the treatment plan for their child. They gained insights into their parent-child relationships.

- Agency workers became aware of the parents' feelings of being isolated and intimidated by a seemingly impersonal agency. Some caseworkers recognized that they tended at times to reject the parents.

- Children in care learned that their parents had not abandoned them after all and could effectively intervene in their behalf.

2. *The combination of casework with group work:*

Positive change was accelerated in all cases through the reciprocal triggering and reinforcement processes of the two treatment methods.

3. *Aftercare:*

The continuation of group and casework services after the family was reunited smoothed the transitional period between the parents' dependency on the agency and their resumption of full parental responsibility.

4. *Maintaining lines of communication:*

The continuing contact of the parent group caseworker with the childrens' caseworkers provided for the coordinated treatment of parent and child.

The project, however, was not a controlled experiment based on a predetermined research design. Therefore, we do not know whether either intensive casework or group treatment alone might have produced similar results. Moreover, the fact of receiving special attention from the agency by being selected for participation in the project might in itself have motivated some parents to work more effectively on their problems with their children. Controlled experiments are needed to shed some light on these questions.

Nevertheless, through the project described here St. Christopher's School has been convinced of the value of coordinated group work and casework for parents of children in care. After the closing of the project in March 1969, the agency raised enough money to resume this type of service on a permanent basis in the fall of that year. At the present time eight parents are participating in this combined casework group work service.

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COMBATTING RETARDATION IN INFANTS WITH DOWN'S SYNDROME

ROBERT B. KUGEL

The disadvantages of institutional care for mentally retarded infants and very young children have long worried persons who work in the field of child development. Numerous investigations—by Bowlby,[1] Spitz,[2] Ainsworth and Boston,[3] Tizard,[4] Skodak and Skeels,[5] Skeels and Dye[6]—have called attention to the deleterious long-range effects of early placement of children, whether normal or defective, in a rigid custodial environment where appropriate stimulation is lacking. Since a child may also be prevented from developing to his highest potential in an unloving and unstimulating family environment, the question may be asked as to whether institutionalization *per se* is the deterring factor when an institutionalized child fails to develop intellectually or socially.

In recent years a number of studies have suggested that institutionalization itself is not so much the deterrent to optimal development of the retarded as the inadequacies in the quality of care in most institutions provided for them in this country[7,8,9]—inadequacies especially in mothering, or "nurturing," and in the particular kind of stimulation needed by the child. That some mentally retarded institutionalized children *can* develop both socially and intellectually if provided appropriate care and stimulation in a homelike atmosphere is strongly suggested by an experiment carried out during 1967 and 1968 by the University of Nebraska Mental Retardation Clinical Research Center.

The experiment was an 18-month study of the development of seven very young children diagnosed as having Down's syndrome (mongolism), a condition accompanied by retardation that until recently has been regarded as inevitable and irreversible. With the purpose of determining guidelines for helping such children achieve greater developmental progress, the experiment provided three program ingredients generally lacking in an institutional setting: a homelike atmosphere, enough staff members to make it possible for each child to be assigned a staff "substitute mother," and continuous stimulating and physically strengthening experiences for each child.

A pilot study designed to provide a basis for more extensive research, the experiment used only gross, though meaningful, measurements of progress. There was no control group, but the progress made by six of the seven children was clearly greater than would normally be expected of children in the condition they were in at entry.

The setting

The first step was to modify the clinical research ward so that it would contain the essentials of a homelike atmosphere and still allow the kind of observation necessary for a research study. Set apart from the rest of the university hospital, this ward includes five 2-bed rooms, a day room, a stimulation-play room, a nursing station, and a fully equipped kitchen

To produce a homelike atmosphere compatibl with the research effort, the day room was furnishe as a living room with both comfort and stimulatio in mind. The floor was covered with red carpeting. not only to make crawling safe but also to give th crawling child strong tactile and visual stimulation The furniture included upholstered chairs and a sof also selected with an eye to tactile and visual stimu lation; an attractive low round table, for its decora tiveness and usefulness; and a television set. Orna mentation included pictures, plants, and flowers, an a colorful bird cage containing a live parakeet.

The playroom was converted into a stimulatio room. The floor was covered with a large blue an green shag rug. Other furnishings included brightl colored chairs of various textures. Paintings, vine mobiles, and wind chimes were hung strategically to attract the children's attention. Brightly colored rings and squeeze toys were suspended from the ceiling nearly to the floor to be within easy reach of crawling infants. Two chromesteel mirrors were attached to the wall at floor level to enable the children to watch themselves at play. Record players, radios, music boxes, and bells were provided as auditory stimulants. Educational toys to aid in developing spatial orientation and color, size, form and weight discrimination were kept within reach of the children. Other equipment included—

- *For balance*—rocking boat, rocking horse, tumble tub.
- *To encourage motor skills*—wooden chairs, a Jolly Jumper, spring chairs, bolsters, tricycles with special pedal attachments.
- *To stimulate interest*—crib gyms, crib aquarium with live goldfish, squawk boxes.

The bedrooms were made homelike with wall plaques, paintings, plants, small rocking chairs, and tables. Patchwork quilts and pajamas replaced hospital spreads and gowns.

The ward always had an inviting appearance. The staff members supplied appropriate seasonal and holiday decorations. They encouraged visitors to come to the ward frequently to talk to and play with the children so as to widen the children's realm of experience and stimulate their efforts to communicate.

The children

In January of 1967, six children, ranging in age from 4 to 17 months, were admitted to the Clinical Research Ward from the Beatrice State Home where each had been placed before he was 6 months old. The seventh child in the study came to the ward sometime later. All the children in the study group had been diagnosed as having Down's syndrome and displayed retarded social and physical development. However, none had additional physical impairments, such as blindness or heart disease.

The group presented a wide range of adjustment problems that had to be considered in program planning. Although four of the seven children were at least 12 months old, only one child could sit alone or crawl. Four of the children had little or no head control; five had habitually open mouths and protruding tongues; and three turned their palms out awkwardly in a posture characteristic of autistic children. Of the three children with awkard hand posturing, one rocked and hit his head against the floor, and two tended to withdraw from human contact. Another child showed signs of rumination, and still another had a weakness of the left side.

All the children required a diet of pureed food because they could not chew. Most of them gagged or spit out the food when more solid food was introduced. Two were still taking milk from a bottle, and four of the older children refused to take any milk.

Vocalization was at a minimum. However, most of the children cooed and one could say "ma-ma" and "da-da." Three rarely, if ever, laughed or smiled—suggesting that they had barely begun to engage in the socialization process.

Staff and methods

The child-caring staff assigned full-time to the ward consisted of two registered nurses and five nurse's aides—a one-to-one ratio of staff to children, although not all staff members were on duty at the same time. In addition, a physical therapist and an occupational therapist from the hospital's staff worked closely with the children. A pediatrician, a pediatric psychiatrist, and a research assistant from the hospital comprised the research staff.

Before and during the project the research staff held a series of meetings with the nurses and aides to apprise them of the aims and objectives of the project. In these discussions emphasis was placed on the concept that the children in care had great need to experience interpersonal relationships with a *few* caring persons.

The experiment used many of the procedures used by Skeels and Dye in their study of the effects of stimulation on mentally retarded children.[6] While we hoped to achieve success through providing each child with attention to his individual needs, as did these investigators, our program differed from theirs in several ways. In the Skeels and Dye study the children were placed in the care of older patients; in our study each child was assigned a substitute mother from the staff on the basis of mutual preference. Thus in our program each member of the nursing staff had primary responsibility for a particular child. To avoid an institutional image, the staff members of our unit all wore street clothing rather than uniforms.

The children in our program were younger than the children in the Skeels and Dye study—averaging 9.8 months on entry as compared with 19.4 months.

Skeels and Dye directed their efforts toward an increase in IQ, while our experiment concentrated on developing the children's adaptive processes and motor skills. This difference in focus derived partly from the younger age of our children and partly from the difference in the nature of their handicap. While the retardation of the children in the Skeels and Dye study appeared to be the result of cultural and familial influences, our children's retardation derived from a specific organic impairment, a chromosomal aberration, which results in the group of abnormalities that together comprise Down's syndrome.

Down's syndrome is characterized by retardation ranging in degree from moderate to mild, floppy musculature and lack of coordination, and often, upper respiratory or gastrointestinal infections that inhibit development. Our experiment gave priority to the correction of the children's motor problems and the development of skills required for socialization, on the theory that success in these areas would favorably influence the child's mental development in later stages.

Socialization

The program of daily care was designed to provide a broad base of environmental and community experiences like those available to the average middle-class, normal child. The supervising nurse, who helped design the program, instructed the nurses and aides in the proper handling of the children and in the initiation of age-appropriate activities for each child. Since children's needs change so rapidly in early childhood, she held instruction sessions weekly.

From the beginning, a nursery school program was held on the ward for an hour each morning and afternoon, except for two mornings a week. During these sessions, each child's substitute mother would work with him on developing various skills and carrying out the exercises recommended for him by the physical therapist. In these sessions the children were also encouraged to play with each other and to use the appropriate growth-inducing toys as soon as they were ready for them.

The child's experiences in the unit also included the kind a child would have in his own home in the routine of daily living—as an infant, being dressed and fed, and later, learning to feed himself and to help when being dressed and undressed; playing with other children; having parties for special occasions; and learning the limits of acceptable behavior. Everything done by the staff in dealing with these routines was done with a developmental purpose. Since consistency has proved to be helpful in teaching mentally retarded children, most activities that involved daily routines were presented in a structured manner. For example, the nurses and aides always dressed the children in the same way.

The staff members provided the children with many new experiences away from the ward. They took the children with them on biweekly shopping trips and for visits to public buildings, the zoo, and other interesting places. Twice a week—on the two mornings when there was no nursery school program on the ward—they took them to the nearby C. Louis Meyer Children's Rehabilitation Institute for swimming lessons. These lessons were given to all the children, even those under 6 months old.

By the time spring arrived, all the children were old enough to play in the center's well equipped playground. In the fall they began to attend a prenursery school at a local church, thus becoming acquainted with normal children. Some of the children also participated in children's birthday parties or holiday festivities in staff members' homes.

The special attention and stimulating experiences afforded each child, along with rewards of smiles and praise for the child's activities, brought these children to a higher degree of sociability and adaptability than had been observed in children of the same ages with Down's syndrome confined to the State home.

Our records show that at the time of admission, one 12-month-old child related very well to others; another year-old child seemed happy but did not relate well. The rest of the children were extremely lethargic; they barely looked at interesting or moving objects and barely responded to the advances of adults or other children. Two of the children displayed some autistic behavior. The records also show that within 2 months, all but one of the children were

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laughing and smiling in response to other voices and to play. The one child who was 17 months old when admitted to the project had learned to respond a little but not as well as the others. However, after about a year this child suddenly began to respond to a new "mother substitute"—a nurse's aide—and from then on made rapid progress.

Motor skills

The physical therapist and the occupational therapist, working as a team, played a major role in the experiment. They observed each child weekly to determine the child's particular needs for developing motor skills and coordination. On the basis of their observations, they would decide on a management plan and instruct the aide in charge of the child in the techniques it required.

The physical therapist also drew up some general guidelines for developing the motor skills of the children in the group. Using the guidelines for normal development as a base, he indicated the areas of physical retardation that inhibit the total development of the child with Down's syndrome and the kinds of efforts that can help overcome these problems. All the therapeutic activities he recommended were also intended to increase the child's awareness of self and environment. Their basic purpose was to help the child develop—

Head and neck control. Most children with Down's syndrome have poor neck control and as a result their heads lag awkwardly. When such a child is propped up in a sitting position or is learning to pivot in a prone position, he tends to extend his neck at an extreme angle.

To reduce head lag and develop muscle tone in the neck, the nurses and aides, under instructions from the physical therapist, allowed the child some freedom of head movement when picking him up from a supine position; they fed the child with his head held in a midline position; and they gave him exercises and activities that required him to move his head.

Sitting. When the child with Down's syndrome first begins to sit up, he spreads his legs wide from the hips and leans forward with his head extended back. These children usually do not rotate to a sitting position, as do children normally, but instead, push themselves up with their arms from a prone to a sitting position, an indication of excess body tension. The inability to rotate is likely due to shortness of the upper extremities and poor trunk tone.

The nurses and aides helped children overcome these difficulties by patiently guiding them through the proper motions for shifting from a prone position to creeping, and then to sitting propped with the hands as does a normal child. When a child learned these movements, his general mobility was greatly increased.

Creeping. Children with Down's syndrone generally display low muscle tone and a marked degree of rigidity in the legs, which make it difficult for them to assume a creeping position.

Therefore, as each child in the unit showed a readiness to creep, a toy skate-board was used to support his abdomen and chest. Most of the children learned to propel themselves in this position by moving their arms, but few used their feet, knees, or ankles to push. To correct their ankle weakness, the children were often put in jump seats or in stationary seats that would allow them to push their feet against the floor. As the children gradually progressed to the crawling stage, they were encouraged to crawl over and around large objects, like the rocking boat.

Standing and walking. The same problems of muscle tone and mobility had to be corrected in regard to standing and walking. These problems made it very difficult for the children to pull themselves to a standing position. As muscle tone and mobility improved, however, some of the children learned to pull themselves up and some moved quickly from there to walking. As a child learned to walk he was encouraged to push wheeled, weighted wagons and carts to strengthen the muscles used in standing and walking.

After 6 months in the program six of the children could walk well and even run and climb. They were then encouraged to engage in activities that develop fine motor skill—for example, putting balls into bottles, fitting keys into locks, and building with blocks. The children also developed fine motor skill through structured play, such as finger games and nursery rhymes that require particular movements. Several of the children learned such movements quickly.

The physical and occupational therapists kept progress notes on each child's motor development. In addition, the child's developmental abilities were recorded monthly on film and assessed against the Gesell developmental scale.[10]

At the end of the program's first year, all of the children could pull to a standing position; three could walk, climb on furniture, and walk up and down stairs, and four were beginning to ride tricycles. All of the children could float in the swimming pool, two could swim across the pool, and two could surface dive.

Progress generally had been good, and in some areas, better than the program planners had expected. The children were functioning up to age in gross motor activities; in fine motor activities they were slightly below the norm for their chronological age. For most of the children, adaptive behavior and even language development were appropriate for their ages; most of them had developed some self-help skill in feeding, dressing, and undressing; and some were beginning to show a little progress in toilet training.

Some implications

The experiment clearly showed that a hospital routine can be changed to be fully supportive of the development of young children. Much of the success accomplished in motor development can be credited to the sensitivity and persistence of the caretaking staff. While the physical and occupational therapists instructed the nurses and aides in developmental methods, these mother substitutes had to be alert to the best ways of motivating each child. They also proved well able to simulate the kind of care a normal, successful mother would provide.

In addition our findings thus far, though based only on a small sample, have added to the accumulating evidence that retarded children will develop better if provided with age-appropriate stimulation. It is too early, of course, to tell whether the gains made in the child's early life will affect his later development.

The Clinical Research Center plans to follow this pilot experiment with a scientifically rigorous study of three types of care. We plan to study three groups of 10 children each, all with Down's syndrome. One group will be cared for at the State Home in the usual manner; another will be reared at home by their parents; and a third group will be cared for in the manner described here.

In the meantime all the children of the pilot study have been placed in foster family homes near the hospital. Their progress will be followed closely by the research unit for at least 3 years so that developmental assessments of the children can be made in their critical second and third years of life. By the time they are 3 or 4 years old, it should be possible to make reliable assessments of their adjustment and intelligence.

What of the children's parents? All of them had followed a physician's advice soon after their child's birth to place them in an institution as soon as possible. Therefore, they had had no opportunity to form any deep relationship to the infant. When asked permission to transfer the child from the institution to the experimental ward, not one parent objected. After the transfer some parents began visiting their children frequently. They were encouraged to take their children home for weekends or out for rides and visits, and some of the parents did so. None, however, asked to take his child home permanently.

Our study has produced material for working with children with Down's syndrome that can be helpful to parents or foster parents who have such children at home. The physical and occupational therapists have already applied the methods they developed on the basis of the observations in this study in teaching parents to work with their children themselves, with much success.

Perhaps this experiment will help convince professional people who influence parents' decisions about their retarded child that much can be accomplished with mentally retarded children when help is available. It may also convince policy makers of the advantages of providing individualized care for retarded children in small groups when family care is not possible for them.

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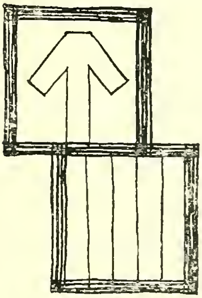

HEAD START'S INFLUENCE ON COMMUNITY CHANGE

LOIS–ELLIN DATTA

In a small northern community, the prevailing general attitude was that the poor are no different from the more affluent—"just lazier." Private physicians alleged that the poor seemed able to afford everything except good medical care for their children, and that if these parents budgeted their money more efficiently, they could afford the health care their children needed. In this conservative town, the general opinion was that each family should pay for what it receives, including medical care. No public health programs existed; nor was there an immunization program, or a maternity or well-baby clinic.

In a predominantly black southern community, a school system now operates a comprehensive health clinic. The clinic is financed almost entirely by Federal funds. This school system has altered its traditional role of educator to include that of health-care provider as well. The idea for a health-care facility was generated by a nurse who realized the need for such a program after examining [Head Start] project enrollees, most of whom exhibited symptoms of chronic disease and malnutrition. Many had never been examined by a doctor. The nurse presented these facts to public health and school officials and requested their help in finding a solution to the problems. Together they worked out a plan whereby the school system would apply for Federal funds to establish and operate two health clinics for children.[1]

The small northern community was one of a sample of seven without Head Start programs described in a recently completed report of the impact of Head Start on community institutions by Kirschner Associates, Inc. The southern town was one of a sample of 58 communities in which full-year Head Start programs were operating in 1968.

The possibility that programs may produce effects beyond those expected for the people directly served is happy but unanticipated for some, a sustaining hope for others, and a primary goal for still others. Reports of institutional change associated with new projects and ideas have appeared frequently since the wave of New Deal social reforms of 1933–1937. Only recently, however, have systematic investigations been initiated to determine to what extent and how social action programs actually change established institutions.

Project Head Start began in summer 1965 as a program to improve the opportunities and development of the children of the poor. The main focus was on the child himself: improving his physical health, his social and emotional development, his relationships with his family and theirs to him, his sense of worth as a person, and his cognitive and linguistic skills. The approach to these goals was consistent with that of the Community Action Program (CAP), of which Head Start was a part.

The objectives of CAP included the provision of direct service to the poor. More broadly, through the mobilization and participation of the people served and the integration of the new programs with other community organizations, CAP strove to create agents for social change in the structure of the community that could endure and spread beyond CAP's direct reach. Head Start's concern for the well-being of children implied even longer-range goals—influencing the philosophies, practices, and activities of other community institutions to become more responsive to the needs of the poor and their children.

The Kirschner study involved extensive interviews with persons involved in Head Start programs, CAP, the school system, health services, and persons with related concerns in 58 communities selected to represent significant Head Start variations—in geographic area, size of the community, type of agency operating the Head Start program through delegation of responsibility, and degree of control exercised by the parents of the children served. Seven comparison communities, with no Head Start programs but matched as well as possible to seven sample Head Start communities, were studied in depth. The researchers found few beneficial changes in the comparison communities while the communities with Head Start programs had undergone many changes since 1965. Local Head Start programs were reported to be influential in bringing about these changes.

A total of 1,496 changes related to Head Start objectives were identified in the 58 communities studied. In over half these communities, more than 25 changes were noted. Of these changes—

- 305, or 20.3 percent, reflected increased involvement of the poor with community institutions, particularly in decisionmaking capacities. For example, in a small southwestern village, a group of Spanish-speaking parents of Head Start children has formed a grassroots organization to exert pressure for changes in school policies and practices. Currently at issue is the school system's regulation *against* students bringing their lunches to school instead of buying them there, even though many children who cannot afford to buy lunches at school must go hungry.

- 51, or 3.4 percent, involved greater employment of neighborhood persons in paraprofessional positions.

- 747, or 50 percent, showed greater educational emphasis on the particular needs of the poor and minorities. For example, a midwestern school system has placed social workers in predominantly black innercity neighborhood schools. Most of these new staff members are black.

- 393, or 26.3 percent, indicated modification of health services and practices to serve the poor better and more sensitively.

Head Start's influence

The fact that salutary change took place in a community with Head Start programs is not compelling evidence that Head Start made a difference in the change. To investigate the role of Head Start, if any, a survey was made of the dynamics of 47 specific changes in 42 of the 58 communities. In the origin of 44 of the 47 changes, Head Start was found to have had a positive influence.

- In 78.7 percent of the 47 changes, the Head Start program was involved in the background stage of change. For example, a school system began to concern itself with malnutrition of poor children—a prevalent condition among Head Start children that came to light during their physical examinations—by applying for funds to provide a hot meal and snacks in the schools.

- In 34 percent of the changes, Head Start participated in the idea-proposal stage. For example, when a large proportion of Head Start enrollees were discovered never to have had immunizations, the Head Start director instigated a persistent campaign that brought about enlargement of the health department's immunization program—for smallpox, measles, polio, and the combined diphtheria, pertussis, and tetanus (DPT) series.

- In 68.1 percent of the changes, the Head Start program was involved in the third stage—support for change adoption. For example, in a western town where a large Spanish-American community felt that the school system had discriminated against their children, Spanish-American parents allied themselves with other active minority groups to campaign for—and elect—a slate of school board candidates who were sensitive to their problems.

- In 8.5 percent of the 47 changes, Head Start was active in the authorization stage. For example, in a small southern town, the Head Start program fought for and won approval from the Office of Economic Opportunity to use Head Start funds to have the local health department administer the Head Start program's medical component, thus making it possible to hire new staff, centralize records, and increase parent contact to the benefit of many low-income children in the community.

- In 12.8 percent of the changes, Head Start was involved in the provision of resources stage. In one large midwestern city Head Start provided training for paraprofessionals employed in various community health services.

- In 21.3 percent of the changes, Head Start was involved in the execution stage. For example, many of the kindergarten teachers in a large city schoo ystem in the west have modeled their classroom cheduling after the Head Start program through he influence of teachers who had formerly been with Iead Start and brought the new, less rigid techniques used in the Head Start centers with them to he regular school system.

- In 72.3 percent of the changes, Head Start supported the execution of change. For example, in a ortheastern city, Head Start parents and staff elped overcome local resistance to "outsiders" staffing a new health clinic by holding meetings in their omes and inviting other area residents to hear discussions of the clinic services and to meet the members of its staff.

Degree of involvement

The Kirschner report showed that—

- The more stages of change in which the Head Start program participated, the greater the benefit, cope, and duration of the change. For example, in , southern community where Head Start was involved only minimally in the development of a eacher aide program for the schools, teacher aides vere employed mainly for the clerical work involved n transferring black students' records to formerly ll-white schools in the year the schools were desegregated. The following year when less money was vailable for the school system, some of the aides, nost of them black people with low incomes, were lismissed.

In another community, the idea of having teacher ides in the schools was proposed by teachers who ad taught in a local Head Start program. School dministrators reported that the aides, who were oor people recruited from low-income neighborhoods, were responsible for a noticeable improvement in the children's motivation to learn and for etter communication with the parents of low socioeconomic status. As a result of the success of the eacher aide program, school officials applied for unds to hire community aides from low-income eighborhoods (another Head Start practice) to isit the pupils' homes and further strengthen the ink between the classrooms and the children's impoverished families.

- Head Start programs were equally effective as hange agents whether they were operated by public chools or new agencies established for the purpose.

- A high level of parent participation in the Head Start program (defined as a high ratio of nonprofessional to professional staff and parent control over selection of staff members) was associated with high involvement of the Head Start program in bringing about institutional change.

- High involvement in change was also related to a high degree of visibility of the Head Start program and its willingness to relate to other local agencies and institutions—that is, where serving as a change agent was specifically defined as part of the local Head Start's program role.

Another finding underscores the complexity of social change. It appears that a "critical mass" for producing social action may be reached in a community with a climate conducive to change and an active Head Start program that sees itself as mobilizing agent. Such a community climate is associated with civil rights activities, the interest and influence of community and professional leaders, and the availability of Federal and State funds to meet the needs of poor children.

These findings buttress the results of a recent study of the Community Action Program as a whole.[2] This study, involving about 100 cities, showed that local Community Action Agencies (CAA's) play two sharply contrasting roles: (1) mobilizing and organizing the poor so that they may make known their needs and interests on matters of public policy and institutional improvement, and (2) supplementing and aiding the efforts of community service agencies. CAA's adopting the first role "were clearly more effective in bringing about institutional change than those that emphasized a service role." In both the Head Start and CAP studies, the researchers emphasize that mobilizing the poor is *not* a militant protest activity, although it may coexist with militancy, but that it "typically involves activities which are well within the boundaries of traditionally accepted and encouraged legitimate political activity: petition-

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Lois-ellin Datta, chief of the evaluation branch of the Research Division, Office of Child Development, joined the staff of Head Start in 1968. From 1963 to 1968, she was a senior research fellow, then a research psychologist on the intramural staff of the National Institute of Mental Health, participating in a laboratory of psychology study on creative adolescents. She received her Ph. D. in psychology from Bryn Mawr College.

ing for redress of grievances, presenting testimony to public policy-making bodies, the enlistment of allies with similar interests."[2]

Further questions

Retrospective studies, relying on the recall of informants and sensitive to the social climate of the research, are inevitably limited sources of information on how programs such as Head Start can change established institutions. Prospective studies, particularly those in which variations in the factors thought to be significant are experimentally introduced, are needed to provide surer and deeper knowledge of the process of role definition and of the pervasiveness, persistence, and longer-range impact of changes introduced.

Within these limitations, however, there seems to be evidence that Head Start and other aspects of Community Action Programs have indeed played significant roles in effecting institutional change. The Kirschner Report concludes:

> One can truly say that these institutions are still not fully responsive to the poor, that the local commitment to change has not been backed by local dollars, and that the available educational and medical technology is not adequate to the needs. But . . . in a short time, with a relatively small investment (less, in toto, per year than the education budget for a state such as New Mexico) Head Start has been closely associated on a national basis with the development of fundamental change in educational and health institutions, two of the most crucial institutional groups in the country.

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guides and reports

FOSTER CARE IN QUESTION: a national reassessment by 21 experts. Helen D. Stone, editor. Child Welfare League of America, 44 East 23d Street, New York, N.Y. 10010. 1970. 275 pp. $4.20.

The first part contains "working papers," prepared by a Practice Commission on Foster Care, that examine the theory bases of foster care practice; the second part, selected papers from the first National Conference on Foster Care in New Orleans, La., in 1967.

SECOND THOUGHTS ABOUT YOUNG PEOPLE. Greater Philadelphia Federation of Settlements, 1315 Walnut Street, Philadelphia, Pa. 19107. 1969. 57 pp. $1.50.

Reports on a 2-day conference of people engaged in Philadelphia's Project MOVE, on why a youth program succeeds or fails, with special reference to "black rage and youths, institutional hypocrisy, action by adults, new roles for youth workers."

FOSTER FAMILY PARENT EDUCATION. Mary Jane Nowak and Mary Reistroffer. University Extension Service, The University of Wisconsin, Department of Social Work, Milwaukee, Wis. 53211. 1970. 68 pp. $3.

Describes a model for group education of foster parents developed at the University of Wisconsin, presenting sample class units and suggested teaching materials, including a bibliography.

ILLEGITIMACY: changing services for changing times. National Council on Illegitimacy, 44 East 23d Street, New York, N.Y. 10010. 1970. 98 pp. $3.25.

Consists of seven papers presented at the 1969 National Conference on Social Welfare, including reports of followup of mothers who keep their children, ethnic variations in views and practices concerned with births out of wedlock, social factors causing illegitimacy, and the use of research in programs.

COMMUNITY PREPAREDNESS FOR RETARDATES: Ralph M. Scheer, Sharryl Hawke, and Norman G. Rice. Austin State School, Post Office Box 1269, Austin, Tex. 78767. 1969. 103 pp. $1.

Presents a program of instruction to help mildly retarded young people adjust to the world outside the institution.

GROUP WORK SERVICES AMONG PREGNANT ADOLESCENTS IN THE INNER CITY. Crittenton Comprehensive Care Program. Florence Crittenton Association of America, Inc., 608 South Dearborn Street, Chicago, Ill. 60605. 1969. 30 pp. Free.

Describes the processes and goals of group discussions with pregnant school-age girls led by social workers and nurses in the Crittenton Comprehensive Care Center in Chicago.

HERE and THERE

–C program

Twelve State and local Community oordinated Child Care (4–C) organi- ations have been officially recognized y Federal Regional Interdepartmental –C Committees, officials in the Office of hild Development said in mid-July. nder Federal guidelines, the recog- ized 4–C organizations will help to co- rdinate all day care and other pre- chool activities carried out by public, oluntary, and commercial agencies in e areas they serve. ("The 4–C Pro- ram," by Jule M. Sugarman, CHIL- REN, March-April 1969).

Parents of children receiving services re fully represented on policy commit- ees of the 4–C organizations.

About 100 communities have estab- shed steering committees for the devel- pment of a coordinated approach to hild care, a major step toward official ecognition. At least 100 other commu- ities have held an initial interagency ommittee meeting or requested infor- ation on how to organize and operate 4–C program.

The recognized 4–C organizations in- lude State committees in Massachu- etts, New Hampshire, and Vermont, nd local committees in Holyoke, ass.; Gary and Indianapolis, Ind.; aco, Houston, and San Antonio, Tex.; cAlester, Okla.; El Dorado, Ark.; and eattle, Wash.

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During fiscal 1970 grants totaling 100,000 for short-term training of day are and early childhood personnel in gencies participating in 4–C programs ere awarded to 16 colleges and edu- ational centers by the Community ervices Administration, Social and ehabilitation Service.

The grants will be used for institutes nd workshops that focus on quality day care, dialogues between users and providers of day care, evaluations of current training techniques, and development of future training and licensing programs as well as training of workers in rural and urban centers. Grants have been awarded to Wheelock College, Boston, Mass.; Southampton (N.Y.) College; Westchester Community College, Valhalla, N.Y.; Virginia Polytechnic Institute, Blacksburg; Georgia State University; University of Mississippi; City College of Chicago (Ill.); Grand Rapids (Mich.) Junior College; Kansas State University; Wichita (Kans.) State University; Chadron (Nebr.) State College; Oklahoma City (Okla.) University; University of Montana; Colorado State College; Center for Early Childhood, Los Angeles, Calif.; and Pacific Lutheran University, Tacoma, Wash.

Teenagers and children

A two-day conference of 60 people was convened in Washington in mid-July by the Office of Child Development to discuss ways of helping young people learn about children's needs through direct experience with them. The participants included child development specialists, social workers, educators, other professional persons, and teenagers who were working with younger children in programs some of them had devised themselves. Of the many points of view they expressed, one was clearly unanimous: opportunities for adolescents or older children to work with younger children in educational, recreational, or child care programs can be developmentally advantageous to each.

At the opening general session Edward F. Zigler, director of OCD and chief of the Children's Bureau, asked participants to make concrete suggestions for a possible federally funded project. Three speakers set the stage for the ensuing group discussions: Ronald Lippitt of the University of Michigan told of experiments in cross-age associations in the Michigan public schools indicating that children can be greatly influenced by those who are 3 to 5 years older than themselves and that there is a "great readiness" among teenagers to work with younger children; Beatrice Whiting of Harvard University described cultures in which children have responsibility for younger children from the age of 5 and as a result develop sensitivity to others from an early age; Urie Bronfenbrenner of Cornell University told of various ways in which Soviet schools promote a sense of responsibility in children, including the practice of having each class be responsible for providing tutorial help and recreational opportunities to children in a younger "adopted" class.

In the four work groups many of the participants expressed doubts that a high school course labeled as a course in parenthood would appeal to young people—or would reach those who might need it most, the high school dropouts. Good parenthood, a number of participants suggested, requires a sensitivity to others that cannot be taught but grows out of a kind of meaningful experience that the schools cannot provide unless they first "become humanized" themselves. Some participants also strongly advocated local participation and the inclusion of teenagers in planning for any project that might be launched, to assure that it is culturally relevant and gives teenagers a meaningful role.

In a panel discussion of teenagers some of the young people expressed strong hostility toward the schools and said they wanted no part of any project that they did not control themselves.

At the final session, the chairman of the conference, Jerome Bruner of Harvard University, drew up a list of "antimonies" from the work groups' reports in which consensus seemed to have been reached regarding any program that might emerge from the conference. In brief they were—

- The program should be carried out outside the school, but should involve the school.

- It should provide teenagers with direct experience with children rather than didactic instruction, but should be supported by materials and experts.
- It should be initiated by young people, but should have a connection with other aspects of the community.
- It should provide a way for young people to help those younger than themselves, but should satisfy their own and community needs.
- It should be locally controlled, locally initiated, culturally plural, but should deal with the universals of child development.
- It should be spontaneous, but should offer school credit and payment.
- It should serve the teenager, but should do genuine service to the very young.
- It should stimulate preparation of materials for local use, but should also make the possibility of such materials known to other local groups.

Family planning

At its spring meeting this year the UNICEF Executive Board for the first time authorized the agency, when requested, to distribute contraceptive supplies to countries being assisted by UNICEF for maternal and child health services in which family planning is an integral part. This decision came after the executive director reported that contraceptives were not readily available to all these countries from other sources.

In 1966, when UNICEF approved a program of assistance in family planning, the supplying of contraceptives was deliberately excluded to avoid controversy and because it then appeared that adequate supplies were available from other sources.

The World Health Organization, which provides technical approval for UNICEF-assisted projects, supports the new policy.

Teens for tots

High school students will be working directly with preschool children in innercity areas during the 1970–71 school year under three Teens for Tots demonstration projects, one in Little Rock, Ark., supported by the Children's Bureau, and two in Chicago, Ill., and San Antonio, Tex., supported by the Sears Roebuck Foundation of Chicago.

The projects are being carried out by the grant recipients—the school system in Little Rock, with a grant of $83,786 that provides for continuing evaluation of all three projects as well as operation of a local Teens for Tots demonstration: the school system in Chicago, with a $46,325 grant; and the Agricultural Extension Service of Texas A&M University with a $44,008 grant for the San Antonio demonstration.

Under the projects, students will be taught basic principles of child development while working with young children and their parents. Objectives of the projects are to enhance growth and development of young children, to teach teenagers ways to facilitate interaction between parent and child, to develop new career opportunities relating to child care, and to prepare teenagers for roles as parents. Although each project has a different focus, all are adapted from models of ways to promote interaction between young children and their parents, developed with the support of Children's Bureau research grants.

In Little Rock about 400 high school boys and girls will work with groups of 5-year-old children and their families as a part of a 1-semester home economics course in family and child development. They will serve as observer-helpers in kindergartens established in two high schools and operated by the Center for Early Development and Education, an agency jointly sponsored by the Little Rock School District and the University of Arkansas. In addition, eight students will be trained for careers as day care assistants through a diversified occupations program. All the students will receive pay for their work with the children and academic credit for classwork. A summer job placement service for students interested in careers in day care will also be established.

In Chicago 30 boys and girls at the John Marshall High School will become infant educators, working in a one-to-one relationship with 30 children under 3 years of age and serving as teaching models for their mothers during biweekly sessions at a neighborhood center. The students will earn academic credit for a course in child development and will receive pay for their work at the center. They will also observe preschool children and assist teachers in Child-Parent Education Centers run by the school system.

In San Antonio 30 Mexican-American boys and girls between 13 and 16 years of age will work in teams of two under the direction of an extension agent. Making two visits a week to the home of a child between the age of 6 months and 2 years, each teenager will spend at least 1 hour interacting with the child and his mother while the other team member will serve as observer-recorder. In the second visit, the two teenagers will exchange roles. Every 2 weeks the teenagers will attend a group seminar to discuss their ideas, needs, and development of the children. Because their work will be focused on the young Mexican-American child's verbal development and concept formation, only bilingual teenagers will be selected.

All three projects include the development of materials and curriculum.

Court decisions

Juveniles who are charged with violating a criminal law are entitled to the constitutional safeguard of proof beyond a reasonable doubt, just as adults are, according to a recent ruling of the Supreme Court of the United States. In a 5–3 decision handed down on March 31, the court held that "the same considerations which demand extreme caution in fact-finding to protect the innocent adult apply as well to the innocent child." The majority opinion, written by Justice William J. Brennan restated other safeguards to which a juvenile defendant is entitled: notice of charges, right to counsel, the right of confrontation and examination, and the privilege against self-incrimination.

The Court ruled unconstitutional the part of the New York Family Court Act that provides that determinations in juvenile hearings be based on a preponderance of evidence, the standard of proof required in civil cases.

The case was brought on behalf of Samuel Winship, who at the age of 12 in 1967 was charged with stealing $112. He was committed to a training school on the basis of "preponderance of evidence" standards, although the family court judge noted that the evidence did not meet the adult standards of "reasonable doubt."

. . .

The Supreme Court also issued two decisions last spring regarding State policies in the program of aid to families with dependent children (AFDC)—one allowing States to set a maximum on family grants and the other prohibiting the reduction of support for a child because of the presence of an unrelated man in the home.

In the case of *Dandridge v. Williams*, the Court by a 5-3 decision overturned a ruling of a Federal district court that had declared invalid Maryland's regulation setting a $240 or $250 maximum on grants regardless of the size of the family. (See CHILDREN, March-April 1969, p. 78.) The Court held that a State does not violate the Social Security Act "so long as some aid is provided to all eligible families and all eligible children," and that it does not violate the Equal Protection Clause of the Constitution merely because the classifications made by its laws "in the area of economic and social welfare" are imperfect, if they are made on a "reasonable basis."

In the case of *Lewis v. Martin*, the Court in a 6-2 decision ruled valid a regulation of the Department of Health, Education, and Welfare that prohibits States from presuming in their compilation of AFDC budgets that a nonadopting stepfather or man assuming the role of spouse to a woman although not legally married to her is providing support for her child. The regulation had been declared invalid by the State of California. In reversing a decision of a Federal Court in San Francisco, the Supreme Court held that unless it could be shown that such a man was actually contributing to the child's support, the State was not free to consider his income in determining the child's need for assistance "whatever the nature of his obligation to support."

White House Conference

Selection of the 4,000 delegates to the 1970 White House Conference on Children to be held in Washington, D.C., December 13–18 will be completed in September. The conference staff and cooperating agencies are making special efforts to insure representation of all segments of the nation concerned about children under 13 years of age. One-third of the conference participants will be under 24 years of age.

Governors will appoint official delegations to the conference from each of the 50 States and the U.S. territories. Other participants will be drawn from national professional and voluntary organizations, government agencies, industry, and private citizens.

To assist in preparation for the meeting, the conference appointed a 20-member coordinating committee in July, composed of 12 adults and eight young people from State committees and voluntary organizations.

Views of how elementary school children view themselves and their world will be presented at the conference through a film, "I'm Me," to be composed of movies taken by children of their own surroundings, skits written, directed, and acted by children, and animated sequences prepared by children; and through a publication featuring art, poetry, and prose created by children under 13 in 11 school districts from Hato Rey, Puerto Rico, to Portland, Oreg.

Hospital care

Parents and medical students have generally approved of an arrangement whereby the parents care for their hospitalized children, but physicians have found that the arrangement makes little difference in the understanding of their communications to the parents about the sick child, according to a pilot study, carried out in 1968, of the experimental Care-by-Parent Unit at the University of Kentucky Hospital in Lexington. The Care-by-Parent Unit consists of 14 private rooms where the mother lives in with the sick child; a nursing station manned by two child care assistants; a lobby; and a utility room for the parents containing a refrigerator, a range, a washing machine, a dryer, a bathinette, an iron, and an ironing board.

The study was carried out under the direction of Melvin J. Lerner, Ph. D., of the College of Medicine's Department of Behavioral Science with a grant from the Children's Bureau. It was preliminary to a larger research plan to determine the effects of an experience in the unit on physician-parent communication, on the family, and on medical education.

The pilot study involved interviews with the parents and physicians of 45 patients. The physicians, on the whole, reported that the parental understanding of their communications about the child's condition and treatment needs was about "average." The study found, however, that the parents had better understanding of the physician's diagnosis than of the prognosis or of the requirements of aftercare. A comparison of the interviews revealed a wide disagreement between parents and physicians about the physicians' expectations regarding the followup treatment of the children at home, especially in relation to diets and medications.

While the study found that the parents seemed more satisfied than dissatisfied with their experience on the unit, it also found that the more specific the questions asked, the more likely they were to elicit criticism.

The effects of the Care-by-Parent Unit on medical students was studied through questionnaires. It was found that an overwhelming majority of the students who had experience in the unit preferred it to the general pediatric ward as both a teaching and patient-care facility. However, many of them criticized the unit's lack of nurses or equipment to care for acute problems. Some students criticized the unit as a teaching section because it did not include patients with acute illness—seriously ill children are assigned to the general pediatric ward. The study found that the medical students liked the increased responsibility given them on the unit to become involved with the patients and their parents.

Foster care

A National Conference of Foster Parents, the first of its kind, will be held in Dearborn, Mich., November 13–15 under the sponsorship of the Children's Bureau, Office of Child Development. About 150 foster parents are expected to attend. In addition there will be about 50 observers from State and voluntary agencies that deal with foster family care. The Christopher Street Society, an organization of foster parents in Detroit that suggested the calling of the invitational conference, is preparing the agenda on the basis of answers to a national mail survey of foster parents and agency workers.

Group programs to prepare foster parents to help the children in their care are feasible for child welfare agencies to undertake, a four-member research team at the Boston College Graduate School of Social Work has concluded after conducting a 2-year demonstration project involving group education of foster parents.

The project, which was carried out from 1967–69 with support from the Children's Bureau, developed and tested methods of educating foster parents in groups and preparing social workers to lead such groups. The social workers from child welfare agencies attended weekly seminars to learn techniques of adult education and group work and the rationale for foster parent education. At the same time, each social worker conducted an educational program for foster parents, who responded readily to such efforts.

As a result of the project, the school has published "A Guide for Foster Parent Group Education," by Albert F. Hanwell, Mary A. Mason, project director, Mae T. Mooney, and Carolyn Thomas. The first section of the guide presents basic materials for fifteen 2-hour classes for social workers. The second section presents an outline for a 12-session course for foster parents.

Copies of the guide may be obtained from the Boston College Graduate School of Social Work, McGuinn Hall, Chestnut Hill, Mass. 02167. (Price: $1.50.)

Adoption

About 101 approved adoptive homes were available in 1969 for every 100 children needing adoption, according to a survey of public and private child-placing agencies in the United States and Canada made by the Child Welfare League of America in early 1970. The 261 agencies in the survey reported having 32,645 homes approved and 32,288 children available for adoption.

However, in her report, Lucile J. Grow, the study director, suggests that a breakdown according to the characteristics of the children would show great variations in the pattern, ranging from an appreciable excess to an extreme shortage, depending on the children's age, sex, religion, physical or mental condition, and, especially, race. Data on all these variables were not obtained in the study.

The study did show, however, that the pattern varied with the type of agency—whether it was public or private and whether it was under religious auspices. Among voluntary agencies, Jewish agencies were found to have the greatest excess of approved homes over adoptable children and Catholic agencies the least. Public agencies, on the other hand, reported fewer homes than children.

All types of agencies, however, reported a large deficit of approved nonwhite applicants for children and a surplus of approved white applicants. About 116 homes of white families had been approved for every 100 white children available for adoption, but only 39 homes of nonwhite families for every 100 available nonwhite children, most of whom were black. The data showed that the agencies were more likely to approve nonwhite applicants as prospective adoptive parents than white applicants: the medians were 61 percent of the nonwhite applicants and 49 percent of the white approved. No information was obtained on whether some of the white applicants would be willing to accept black children.

Deficits of approved homes to total available children were found in Canada, and the Middle Atlantic and Pacific States.

In her report, "New Look at Supply and Demand in Adoption," Dr. Grow warns against accepting the findings of the survey without question because of the variation in what agencies consider an "application" or what kind of a child is considered as "available" for adoption.

The report is available from the Child Welfare League of America, Inc., 44 East 23d Street, New York, N.Y. 10010. (Price $1.).

For the retarded

Since the summer of 1969, a librarian from Adriance Memorial Library, Poughkeepsie, N.Y., has been making regularly scheduled visits to the Dutchess County Mental Health Center to conduct a story and music period for severely retarded children and adults. The program is conducted by Esther Kando Odescalchi, head of the library's extension service.

Mrs. Odescalchi visits the center once a week in the winter and twice a week during the summer taking along books, films, and phonograph records appropriate for young children. She usually conducts two 30-minute story and singing sessions, each with about 15 patients.

The listeners range in chronological age from 5 to 30 years. Many of them are confined to wheelchairs because of physical handicaps, such as cerebral palsy.

Because of her listeners' short attention span, the librarian tells stories that only last about 10 minutes. She selects a narrative that is easy to follow and omits confusing details. Speaking to each member of the group by name, she encourages interruptions and questions and also asks questions of her listeners. She walks around the semicircle to show pictures and to let each person touch the book. She has found that the children are fascinated by stories of witches, flying horses, dragons, and other supernatural creatures.

After the first story, the librarian plays familiar songs on the piano. She has found that the children—even those who do not speak—generally respond enthusiastically to music.

Child abuse

A total of 586 suspected cases of child abuse were reported to the Pennsylvania Department of Public Welfare in 1969, an increase of 3.2 percent over the 568 cases reported in 1968.

Under Pennsylvania's child abuse reporting law, physicians must file a written report with the county child welfare agency whenever examination of a child under 18 discloses evidence of gross physical neglect or injury that may have been inflicted by another person.

Forty-nine of Pennsylvania's 67 counties reported one or more cases of suspected child abuse for the year 1969. Among the injured children males exceeded females by a small margin. Swellings, bruises, and welts were listed as the most common diagnosis; beatings, fractures, and burns, as the most frequent types of abuse.

The greatest number of abused children were in the age group 5–9—a change from the previous year when the highest incidence of abuse was among 1- to 2-year-olds.

Protective services by child welfare agencies were provided for 58.2 percent of the children reported as abused in 1969; 10 percent were removed from their homes at least temporarily.

The abused child's mother was most frequently listed as the suspected abuser followed by the father and stepfather. One fifth of the suspected abusers had been involved in previous cases of child abuse.

BOOK NOTES

ANOREXIA AND OBESITY. Christopher V. Rowland, Jr., M.D., editor. Vol. 7, No. 1, International Psychiatry Clinics. Little, Brown and Company, Boston, Mass. 1970. 360 pp. $8.50.

Two psychophysiological disorders that occur in children as a result of improper food intake are examined in this book by research workers in the fields of psychiatry, clinical medicine, nutrition, and psychology.

Anorexia nervosa is defined as a state of self-inflicted starvation involving extensive disturbances in personality development that occurs chiefly, but not exclusively, in girls about the time of puberty. Part I of the book includes a discussion of changing approaches to anorexia nervosa during the 20th century; a review of 30 case studies; and a study of twin sisters, one normal and the other suffering from anorexia.

Part II discussed obesity in juveniles, its course and outcome; some aspects of the problem of regulating food intake in obesity; and psychotherapy and eating disorders.

THEORY AND PRACTICE OF SOCIAL PLANNING. Alfred J. Kahn. 348 pp. STUDIES IN SOCIAL POLICY AND PLANNING, Alfred J. Kahn. 326 pp. Russell Sage Foundation, New York, N.Y. 1969. $8.75 each.

The first of these companion volumes presents a model for planning that gives weight both to the struggles inherent in interest-group politics and community organization and the interplay of power between the politics and rationality of choice. The evolving theoretical conceptualizations concerning policy formulation provide a basis for blueprinting a dynamic planning process that may begin at any point, but will ultimately include consideration of problems and needs, definition of the planning task, formulation of the standing plan, programing, evaluation, monitoring, and feedback.

The author explains each of these components in detail. Though he emphasizes social welfare planning, he presents a synthesis of the development of planning theories in many areas, particularly economics. While he clearly specifies his own definition of critical concepts, he examines many different definitions and leaves the reader with the choice of using whatever frame of reference he prefers.

In providing perspective, the author briefly discusses the proposed strategy of "disjointed incrementalism" for dealing with the problem of the complexity of our society and the increasing interdependence of all components.

"Studies in Social Policy and Planning" provides case studies primarily from Federal programs that were developed in the '60s: antipoverty war, children's programs, income security, city planning, mental health, and social services delivery systems.

THE DEVIL HAS SLIPPERY SHOES: a biased biography of the Child Development Group of Mississippi. Polly Greenberg. The Macmillan Company. New York, N.Y. 1969. 704 pp. $14.95.

This is the story of the growth, development, and hard times of the first Head Start program in Mississippi as told by one of the initial organizers and member of the Mississippi project's central administrative staff. Taking the viewpoint that centers for preschool children in the poorest sections of Mississippi could do little for the children unless they grew out of the parents' own efforts, wishes, and pride, the staff focused its efforts on orienting people in isolated Negro communities to the possibilities of getting Federal help for doing something for their children, identifying natural community leaders, helping them to organize themselves and determine what they wanted for their children, and providing them with technical assistance when a problem arose.

Eighty-four preschool centers were in operation before the end of the first summer (1965)—22 of them with excellent programs, 19 of them "pretty terrible," and the rest of them with great possibilities, according to the author. She says: "The hardest thing in the world that summer was to withhold and watch and 'let' human beings develop." But the staff stuck to its convictions that "cracking the steel case of parental futility feelings comes before 'fertilizing' the child" and that *that* would have to mean not only parental involvement but parental control of all aspects of the project.

Much of the book is devoted to a description of the difficulties arising with "far-off Washington" when such a hands-off policy had to be combined with the requirement for accountability. It also tells of harrassment of the project from within the State.

CITIZEN BOARDS AT WORK: new challenges to effective action. Harleigh B. Trecker. Association Press, New York, N.Y. 1970. 288 pp. $7.50.

Addressed to the men and women who serve on boards of directors of community service agencies, this book examines the role of board members in meeting the social, educational, cultural, religious, health, and other needs of their areas. The author, a professor at the University of Connecticut School of Social Work, discusses the difference between policy-making and advisory boards; the relations between board members, the executive, and staff members of the agency; the concepts of representation and balance in building and organizing the board; the obligations of the board to the agency's constituency and to the community as a whole; the handling of conflict; and board member training as a continuing necessity.

The book lists six challenges that face members of today's boards: agency control; responsible participation; service organization, availability, and delivery; manpower recruitment, utilization, and salaries; finance and budget; and central planning. It points out the need for periodic evaluation of the work and objectives of all boards. An agenda for action presents ways of increasing an agency's abilities to meet the changing needs and demands of the times.

IN THE JOURNALS

Influences on self-image

A study of the relationship of children's self-esteem to some selected aspects of their lives is described by Robert R. Sears of Stanford University in the June 1970 issue of the quarterly, *Child Development*. ("Relation of Early Socialization Experiences to Self-Concepts and Gender Role in Middle Childhood.") The subjects were 159 sixth grade children—84 boys and 75 girls—whose mothers had been interviewed 7 years earlier regarding child-rearing practices and other family factors.

The author reports that the children's degree of self-satisfaction was measured by a Self-Concept Inventory through which they did a self-rating of their physical and mental abilities, their competence in various aspects of social relations, and a number of other qualities. The resulting scores were correlated by the author to information obtained in the earlier study about the family and the child—the degree of parental warmth, father or mother dominance, and the child's birth position—as well as with tests of the child's degree of femininity and degree of aggression.

The author reports that for both sexes a highly positive self-concept was associated with the presence of parental warmth—whether maternal or paternal—small family size, and being the oldest child in the family; that low father dominance was associated with highly positive self-concept in boys only; that warmth on the part of the father was associated with femininity in girls and masculinity in boys; and that femininity—as measured by occupational, recreational and other preferences—was associated in both sexes with poor self-concepts and feelings of aggression. He also reports an association between a highly positive self-concept and the child's IQ and his achievements in arithmetic and reading. The latter achievements, he says, are better predictors of a child's self-concept than is his IQ alone.

New methods

A child guidance program designed by questioning the assumptions of traditional treatment programs—that improvement in parent-child relationships can only be brought about by the resolution of inner conflicts or marital difficulties—is described in the July 1970 issue of *Social Work* by Norman Epstein, director of social work and group therapy at the Children's Psychiatric Center, Eatontown, N.J. ("Brief Group Therapy in a Child Guidance Clinic.")

On the theory that "one of the most difficult life tasks is that of parenthood," the clinic has evolved a system of brief therapy that is focused on educating parents and their first-born or only children to improve their competence in coping with one another, the author reports. In this program the parents are helped to alter their expectations and see alternative ways of dealing with the child in six weekly meetings with other parents in which the therapist—who may be a social worker, a psychiatrist, or a psychologist—takes an active role as clarifier, counselor, and teacher. At the same time in individual sessions, the child is helped to see how his behavior affects adults and to find more successful coping strategies. The agency also conducts short-term group sessions for adolescents.

The author reports that the agency is reevaluating the concept of long-term treatment, although it still carries out extended treatment for a few clients who do not seem to benefit from the shorter program. Staff members, he says, have moved away from "the compulsive seeing of pathology" to a greater acceptance of a wide range of behavior and to a more active involvement with community resources in behalf of the child. Since the inauguration of the brief therapy program, the waiting period for treatment at the agency has been reduced from over 6 months to 8 weeks.

Fantasy in adopted boys

Although the common fantasy of children—that the adults with whom they live are adoptive parents or stepparents—is no fantasy for adopted children, the tendency of an adopted child to romance about his natural parents poses no real identification problem for the child adopted in infancy, says Edward M. Schwartz in the July 1970 issue of *Child Welfare*. ("The Family Romance Fantasy in Children Adopted in Infancy.") The author bases his conclusions on a comparative analysis of the identification behavior of two groups of boys from upper-middle class families in Ann Arbor, Mich., one group composed of 25 boys placed in adoptive homes before the age of 6 months and the other a matched control group of 25 boys living with both natural parents.

Pointing out that he finds no indication that prolongation of the "family romance" is a universal characteristic of children adopted in infancy, the author notes that the adopted boys in his study show a positive interest in and acceptance of their adoptive parents as role models on a level similar to that of their nonadopted peers. The boys were curious about their biological parents in regard to their physical appearance, whereabouts, or reasons for not keeping their sons, the author says. However, only two boys perceived their biological parents in fantasy as "particularly special in a positive sense."

The author warns against concluding from his observations that fantasy does not affect children adopted at a relatively older age or brought up in "one or more foster homes."

Dr. Schwartz is an instructor in psychology at the University of Michigan Medical School.

PKU screening

The interrelationships of physicians in populous areas is "a most influential factor" in supporting or hindering voluntary programs for the mass screening of newborns for phenylketonuria, maintain three physicians from the University of Washington School of Medicine in an article in the June 15, 1970, issue of *JAMA*. ("Some Factors Influencing the Development of a Voluntary PKU Screening Program," by Vanja A. Holm, M.D., William M. Deering, M.D., and Rhesa L. Penn, M.D.)

Reporting on a statewide voluntary program for screening newborns, they cite a large Washington county in which a low incidence of testing was directly related to a decision by a group of physicians not to endorse PKU screening, although the procedure was accepted medical practice in other communities in the State and was supported by the Washington State Medical Association and the State Department of Health.

On the basis of questionnaires returned from nearly all hospitals with obstetrical services, the authors report that the percentage of newborns tested for PKU in the State increased from 45 to 69 percent between the years 1965 and 1967. They found variations in screening adequacy among hospitals of all sizes, ranging from less than 10 percent of newborns screened to over 80 percent. A greater proportion of the hospitals with over 700 births a year reported testing at least 80 percent of the newborns than hospitals with fewer births. The authors also found that hospitals do not automatically maintain screening programs at a high level once it is achieved; that the attitude of the hospital's medical staff toward screening procedures affects the level of screening reached; and that a mandatory testing policy within a hospital does not always bring a high level of achievement.

Pointing to a need for a coordination of various types of screening programs for newborns, the authors suggest that consideration will need to be given in the future to the as-yet-unresolved issue of voluntary or legislated screening.

READERS' EXCHANGE

GROSS: Evidence of the possible

Norman Gross in his article, "Reaching for the Dream—An Experiment in Two-Way Busing" (CHILDREN, July–August 1970), reports what I believe many of us who have worked with the issues of busing school children to achieve better racial integration have noted again and again—that black children and white children from different backgrounds and varying circumstances can come together and learn about one another, and learn more effectively as individuals. It is not impossible in this country to find significant numbers of white people who are quite willing to have their children transported from an immediately nearby school to a distant one that offers special advantages.

I have come to believe that the whole issue of busing is a false one. For years all through the South and Appalachia I saw poor white children bused miles and miles, and no one was unhappy about it. Furthermore, I saw white children bused in order to avoid integration with black students. That also is the case in many northern cities and towns. The word "busing" has aroused a great deal of fear and anxiety in parents, but on the basis of my work with many anxious parents, I have learned that the fear is not so much of the bus, or the travel, but really has to do with two words that I used to hear over and over again in Mississippi and Louisiana, and now hear frequently in the North, "race-mixing."

Because some people are afraid of getting to know their fellowman, there's no reason for those many who are quite eager to come to know others to become pessimistic. The experiment that Mr. Gross describes may not be universally applicable; but there *are* many white people and black people all over this country who are willing to initiate similar experiments and who deserve encouragement and support.

What children learn in such experiments is not the kind of knowledge that can be easily quantified. Learning and education have to do with ethical values and with the heart and spirit as well as the brain. The kind of experiment that Mr. Gross describes offers some hope that this country has in it more than a collection of self-aggrandizing "groups," utterly unwilling to reach out and respond to neighbors, fellow citizens, fellow human beings.

As a clinician who has worked with so-called lower middle class white families, many of them outspokenly racist, I can say that even in the most fearful and suspicious people, there are elements of real concern and compassion. We often underestimate people because we are unwilling to educate both them and ourselves to what might be possible, given not only understanding, but real determination and courage. As a child psychiatrist I know what children are capable of—whatever their background or race. I am a little less hopeful of social or political institutions.

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GARRETT: Foster parents' rights

I read with much interest the compilation by Beatrice L. Garrett on "The Rights of Foster Parents" in the May–June 1970 issue of CHILDREN. I would like to suggest expansion of item 10 which deals with the opportunity to be listened to regarding agency practices.

If a foster parent is to have a "right" concerning practice, I feel that the same parent should have a right regarding *policy*, which establishes the grounds for program formulation and practices. Foster parents should not only "be listened to" as staff members, but should also have an active decision-making role shared with others in agency policies. I believe that foster parents would then have a clearer identification as to their roles in relation to natural parents, children, the agency, and the community and less of a problem in deciding whether they are "fish or fowl."

Paul A. Guerard
Field representative
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The right to learn

I was gratified to see Miss Garrett's suggestions for implementation of a people-to-people approach to foster parents.

Remnants of a depersonalizing agency-to-people method still maintain, and Miss Garrett's recommendation definitely turns away from this outmoded system.

I would like to suggest one particular "right" for emphasis: professional education. Although training and staff development is implied in Miss Garrett's list of rights (numbers 1, 2, 3, and 6) I would still urge that specific mention be made of education of the foster parent even above and beyond supportive and informative involvement in the agency's program.

Foster parents have responsibility for a tremendously significant contribution to society. They are, as Miss Garret affirms, entitled to "opportunity to learn and grow" (right number 9). I submit that this should be highlighted by stating that foster parents have the right to appropriate education or training for their roles, or both.

Sister Mary Patrick
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BOYLE: Service and social change

I am intrigued by the article in the July–August issue of CHILDREN, "A Learning Experience in Helping Parents Get What They Want," by John Boyle and the "Epilogue" by Dorothy Randolph. This material raises many issues, all of which are tempting to comment on. Mr. Boyle himself in his summary raises very pertinent questions.

As a social work educator I find it difficult to pass up the opportunity to talk about the rich learning experience available to Mr. Boyle in his field work. I regard his material, along with the "Epilogue," as important documentation in support of a unified view of offering people in trouble direct services and at the same time seeking to affect or modify the social policies that bear upon them. We are in an era in which social planners and practitioners too often tend to view each other across a gulf and with mutual suspicion.

In struggling with the group process, Mr. Boyle found that the key needed to elicit significant participation from the group members was involvement in planning for a concrete result. He was somewhat taken aback by the amount of work that he himself had to do in the face of the slow and laborious development of action groups. Nevertheless, one could point out that the parents in articulating their children's needs and in playing some part in bringing about the Saturday program and the eventual school, were functioning most appropriately *as parents.*

I wish this point had come through a little more clearly—that the parenting role is not separate nor apart from the social change role in this kind of situation. Mr. Boyle was able to provide direct service while simultaneously functioning as an agent of social change.

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BRANHAM: Implications for unwed parents

Ethel Branham's excellent article, "One-Parent Adoptions," (CHILDREN, May-June 1970) has important implications for work with unwed parents. Knowing about the apparently successful efforts of the Los Angeles County Department of Adoptions in finding secure adoptive homes for children in single-parent families ought to reassure not only child placement workers, but also workers who are involved in parents' choices, of the possibility of finding adoptive homes for "hard-to-place" children. In addition, the program's effectiveness should have meaning for unwed parents who are considering surrendering a child to an agency's care.

Ideally any unwed mother should be able to surrender her child if she is psychologically ready to do so. However, some mature unwed mothers who are aware of the many "hard-to-place" children needing placement may only be willing to surrender their child to an agency if the agency assures them that the child will be adopted. Without definite adoptive possibilities, the worker or the adoption agency, or both, may consider it unconscionable to accept responsibility for a child from an unwed mother if that mother is psychologically mature and motherly by nature, and so might have more to offer the child than does the agency. (Needless to say, many adolescents and others too would not fall into this classification.)

A one-parent adoption program, even though a second best choice for a child, offers the agency and the mother a real alternative to the uncertainty of waiting for a two-parent home. For a mother who is confronted with the trauma of surrender along with other emotional problems, the certainty that her child will be adopted is a healing and supportive force.

An unwed mother, and others, may well ask: what can a single adoptive parent offer a child that an unwed mother could not offer by keeping her child herself? In the one-parent placements described by Mrs. Branham, the adoptive parents held such positive attributes for parenthood as healthy motivation for wanting a child, joyfulness about child-rearing, and ability to plan adequately and realistically for the child. Such attributes may be missing in an unmarried mother who keeps her child only because there is no alternative.

Other positives provided in the program described derive from the criteria established for selecting single-parent adoptive homes, notably emotional maturity on the part of the applicant and the availability of suitable substitutes for sexual identification. The Los Angeles County Department of Adoptions has provided an inspiring example of flexibility, determination, innovation, and creativity in meeting the needs of children who otherwise would, in a sense, be homeless.

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OLUNTARY ACTION TO STOP RUBELLA! HEW, PHS, Center for Disease Control, Atlanta, Ga. 30333. 1970, 12 pp. Single copies free from CDC.

Describes ways in which voluntary ction groups can help in programs to op rubella.

IENTAL HEALTH AND THE DEAF: approaches and prospects. A report of the National Conference on Mental Health Services for Deaf People, sponsored by the New York State Psychiatric Institute, Houston, Tex.—February 14–17, 1968. Kenneth Z. Altshuler, M.D., and John D. Rainer, M.D., HEW, SRS, Rehabilitation Services Administration. 1969. 162 pp. Single copies free from the Institute, 722 West 168th Street, Houston, Tex. 10032.

Contains the keynote address and re- ource papers prepared for the confer- ice and summaries of the discussions ıd the proposals of discussion groups on education, psychology, rehabilitation, religion, and social work in relation to work with deaf children and adults.

CHILDREN OF DIVORCED COUPLES: United States, selected years. Vital and Health Statistics. HEW, PHS, National Center for Health Statistics. PHS Publication No. 1000, Series 21, No. 18. 1970. 40 pp. 50 cents.

Through the use of tables and charts, this booklet reports on divorces involving children under 18 years of age in the United States. It points out that the number of children involved in divorces has increased sixfold since 1922 and has doubled since 1950.

RESEARCH RELATING TO CHILDREN: bulletin No. 25 (April–December 1969). HEW, OCD, Children's Bureau, Clearinghouse for Research in Child Life. 1970. 131 pp. $1.25.

Contains brief descriptions of current or recently completed research studies reported to the Children's Bureau between April and December 1969, dealing with child growth and development, personality and adjustment, special groups of children, the child in the family, socioeconomic, cultural, and educational factors in development, and social, educational, and health services.

MENTAL HEALTH DIRECTORY 1970. HEW, National Institute of Mental Health, National Clearinghouse for Mental Health Information. Publication No. 1005. 1970. 455 pp. $4.

Lists more than 3,000 facilities in the United States, by county, that provide mental health services; gives type of service, address, and areas where the services are administered.

CHILD CARE SERVICES PROVIDED BY HOSPITALS. Department of Labor, Wage and Labor Standards Administration. Women's Bureau Bulletin 295. 1970. 34 pp. 25 cents.

Gives results of a survey of 3,000 hospitals having 100 or more beds to learn how many have child care centers for their employees. A total of 98 hospital child care centers were reported, 79 of which are in the hospital or on the hospital grounds.

EW refers to Department of Health, ducation, and Welfare; OCD, to Office ' Child Development; PHS, to Public ealth Service; SRS, to Social and Re- ıbilitation Service.

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children

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DEPOSITORY

children

Teenagers Discuss Drug Use

Foster Care for Retarded Children

Identity and Foster Care

Children With Hemophilia

VOLUME 17 • NUMBER 6 • NOVEMBER–DECEMBER 1970

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Two adolescents of the seventies—their major task to synthesize the developmental accomplishments of their past with their personal qualities, social ideals, and the opportunities available to them. What they will become, as one article (p. 213) in this issue suggests, is influenced by what their "environment has permitted and now permits and encourages" and their "own talents, needs, and defenses." The lead article gives us some adolescents' views of one confusing aspect of their environment—the use of drugs.

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"I think more people (adults) need to know just how teenagers think of drugs and why they take them."

In this response to a question from the Children's Bureau, a high school student unwittingly expressed the Bureau's own reason for making drug use the subject of the second inquiry to its 415 Youth Reporters. These reporters—all high school students preparing for college—had been selected at random from metropolitan areas in the North, South, Midwest and West, in both central city and suburban high schools. Early in January 1970 the Children's Bureau sent them four questions:

How do teenagers feel about the use of the various kinds of drugs by people their age? Do they feel differently about different kinds?

What makes some teenagers use such drugs?

What keeps some teenagers from using them?

Should adults take steps to discourage the use of drugs by teenagers and/or older people? If so, which adults should take steps and what steps are advisable?

As with its first Youth Report, on the generation gap,[1, 2] the Bureau's intent in soliciting letters from high school students was to find the main patterning of opinions among such young people, rather than to obtain an exact count. As the questions indicate, the Children's Bureau was concerned with attitudes rather than with the extent of drug use. It wanted to learn what young people think about the use and users of various kinds of narcotics and what they think ought to be done about the drug problem

Replies were received from 205 students in 5 schools in 12 cities—a return of nearly 50 percent This is a lower response rate than in the preceding inquiry, but nevertheless an unusually high one fo a mail interview.

About one-fifth of the correspondents discusse the questions with friends or classmates before sending in their answers. One sent in the results of questionnaire answered by 435 students.

DRUG USE AMONG THE YOUNG

AS TEENAGERS SEE IT

The young people's reports show some points of rong consensus, some points on which opinions vide rather evenly, and some on which a dissenting inority is substantial. Moreover, each group of opinns embraces a wide array of shadings and angles. A detailed description of the inquiry and its results being published by the Office of Child Development the second in its series of *Youth Reports*.[3] Here e will present only an outline of the general patrns of response, along with some illustrative cerpts.

ow much they know

Although the questions were not designed to meare how much the Youth Reporters know about ugs, their reports show that at least half the correondents do know something about them—ranging om detailed information through recognition that fferences in drugs exist, to a general separation of arijuana, or "pot," from all other drugs. More than fourth lump all drugs together as bad.

> I'm not against marijuana at all depending on the person and surroundings. Speed (methedrine, dexedrine, benzedrine, .) and amphetamines are very dangerous and I'm down on em . . . . I'm down on all cheap trips and highs caused by ing large doses of household drugs or by inhaling products th a freon or methane base. They're extremely dangerous and reliable. STP (a very potent hallucinogen) is also dangers . . . . I think use of psilocybin, peyote, and its derivative escaline, are okay and better than LSD because they come om natural sources . . . . LSD *in its pure form* can be a autiful drug . . . . Heroin, morphine, opium, and cocaine e fantastic, but unfortunately addicting, so I can't condone eir use.

A few reporters maintain emphatically that young ople are very well informed, but others insist herwise.

> . . . We are taught in school, on T.V., at home, in books and magazines, and by friends about drugs. We know what will do what and what won't. When somebody uses a drug, the odds are he knows exactly what he's doing.

> . . . But last is the dreaded confusion caused by contradiction in the reports of what drugs cause. Some say it is nothing, others say it kills, some say it helps one see differently, others say it destroys the mind. There is no one to believe and no one to turn to to gain the real truth. . . .

Pot and addiction. Opinions differ as to whether marijuana is or is not addictive, although only about half the correspondents comment at all on this point. About one fourth apparently think marijuana leads to addiction, either physically or psychologically. They say, for example, that it "leads to easy access to other drugs," that it may cause a person to feel "brave" enough to try something stronger, that "they like the high and want to get higher."

> Some teenagers say, "Just once or twice and I won't get hooked." This usually isn't true. . . .

About one in eight, on the other hand, says that marijuana does not lead to addiction or to use of other drugs. "Kids are smart enough not to get hooked usually . . . ."

Nearly half of the correspondents give evidence in their reports that they have acquaintances who use drugs at least occasionally. Only ten directly state that they do not know any users. As many as one in seven say they know drugs are in their school, while only two state explicitly that their schools have no drug usage.

> In a class discussion today everyone agreed that they knew at least one person who had experienced the use of a drug or was a habitual user.

> Although the percent of kids who do use drugs is not

unusually large, the percent of kids who would absolutely refuse to take drugs is very small.

A few correspondents point out that many young people try marijuana or a "harder" drug only once or twice, to see what it's like. About a fourth explicitly disclaim using any kind of drugs themselves. Less than a tenth say or imply that they do use marijuana and only two that they use other drugs.

I personally have tried pot but I know I wouldn't want to continue on it. I think many experiment with drugs but the few who stay with it stay on it for a reason.

Attitudes toward drugs

Almost half the correspondents accept the use of pot, but within this half, four out of five explicitly reject the use of harder drugs. On the other hand nearly two-fifths of the correspondents express disapproval of all types of drugs. Only two reflect approval of "hard drugs," but about one in 20 reflect a tolerant attitude toward some other drugs, usually the amphetamines. A few call LSD and heroin "suicidal." "Pep pills," "pot," "hash," and barbiturates, when mentioned, are more generally viewed as safe.

Most don't have any qualms about tranquilizers, alcohol, Contac, aspirin, muscle relaxers, etc. As for drugs which are not in the mainstream of adult life, opinions are varied—marijuana is fairly accepted, whereas pep pills, acid, and narcotics are controversial.

Attitudes toward drug users resemble attitudes toward drug use. Those correspondents who express disapproval of all drugs report that drug users are considered "stupid," "crazy," "dangerous," "disgusting," "irresponsible." Some also say that drug users are rejected socially.

. . . The majority of teenagers today look down on drug users. They feel that drug users have no character or ambition, are not mature enough to handle the problems of life. They are a menace to society . . .

A larger proportion (more than three out of five) report mixed opinions, often because use of hard drugs is rejected, while the use of pot is regarded as "no worse than liquor" and "not as harmful as tobacco." Sometimes the reporters describe varying attitudes among the persons they know.

Ironically, there is a tendency to degrade a pot smoker and to feel sorry for the hard drug addict.

The varying shades of acceptance range from indifference to accepting without condoning. "It's their own life;" "a person has a right to wreck his own life if he wants to."

We believe we have witnessed, read, and felt enough about drugs to be able to say whether we can use or not use them . . . In general we say if a person wants to take drugs, let him and stop him only when it affects others.

Over one-fourth of the correspondents express some variation of this laissez-faire theme. About half as many say that drug users are accepted and even admired by some young people, who consider them brave, superior, "hip," "out of sight."

. . . In the midst of a group discussing their hallucinator experiences, a nonuser feels positively left out.

A smaller proportion speak of compassion and pity for those who are "hooked." "It's really sad—you ca see tombstones in their eyes."

Reasons for drug use

Almost everyone who answered the questions at al had something to say about why teenagers use drugs and nine out of ten commented on why some teenagers do not. Often the reasons for use and for nonuse represent two sides of the same coin.

Some of the reasons given could be described a "positive" in the sense that they represent somethin desired or approved, and some as "negative" in th sense that they represent something to be avoided o resisted, or lack of an approved attribute. A few ar "neutral," in the sense that they merely describe situation.

"Negative" reasons for drug use. Leading all reasons "positive" or "negative," reported for using drugs i the *impulse to escape*, mentioned by almost seven i ten of the correspondents. Most often the impulse i attributed to individual or family problems: parent who "don't care enough," a stressful home situatio the "generation gap," pressures to achieve.

Elizabeth Herzog (right), Cecelia E. Sudia, and Jane Harwood were all with the Children's Bureau research division when they began working on the second study in the *Youth Reports* series, of which they give a preview in this issue. Miss Herzog, after 16 years with the Children's Bureau, last April joined the social research group of George Washington University. Still with the Children's Burea Mrs. Sudia and Miss Harwood are respectively researc analyst and research assistant.

For many teenagers, drugs are the only way to escape the aotic situation around them . . . . With drugs, they hope to who they want, where they want, when they want . . . .

However, about one in ten attributes the escape npulse to despair with the world and the social oblems that seem unsolvable—"questions which lults either cannot or are afraid to answer . . . ce, religion, economics, sex, etc."

The impulse to rebel appears about one-third as ten as the impulse to escape. Teenagers who turn drugs to satisfy or express rebellion are pictured wanting to challenge the law, defy parents and her authorities, retaliate against prim and prudish gulations.

Kids do things because they are forbidden, because they want find why it is forbidden.

About one in ten relates drug use to inner psycho-gical problems—isolation and loneliness, identity onfusion, loss of direction.

They feel if they tear themselves apart piece by piece they ay find the answer.

Mentioned with equal frequency is the problem f "nothing better to do," boring routine, a sur-ounding emptiness.

There is *nothing* a young person sees as more frightening an a life of dullness and endless routine. I think this feeling omes from the routine we must bear in school.

More correspondents mention "positive" than negative" reasons for drug use, but the great ma-ority (about seven in 10) mention both types.

"Positive" reasons for drug use. Three "positive" easons for drug use appear with almost equal fre-uency, each being mentioned by about two in five orrespondents: (1) status or image—a desire to look big," "be cool," "show one isn't chicken;" (2) onformity—a need to follow the crowd, be ac-epted, achieve "this belongity;" (3) curiosity—a esire to "see what it's all about."

In my opinion, people who use drugs are using them to get place in society. Guys think they're tough and girls will idolize em. Girls think guys will like them because they're not hicken.

The teenagers that use drugs probably do so because they ant to see what it is like. . . .

Almost as frequently mentioned is the search for xcitement—the wish for "kicks and thrills."

More and more of my friends are now using acid . . . it's just more exciting than the ordinary school day according to a boy in class with me who drops acid at least three times a week.

About one in five mentions the reach for aesthetic rewards—the wish to expand the mind and senses, to enhance creativity and insight, to revel in "the overwhelming sense impressions." One includes "religious ecstacy" and another "improved sex."

Others take drugs because of want to be artistic and explore a new world. So use the drug to benefit from it to look at life in a different perspective . . . I can understand using a drug for this reason but no other.

Reasons for non-use

While the correspondents more often mention "positive" than "negative" reasons for drug use, the picture is reversed in their explanations of non-use, although about half give both kinds of reasons. That is, the tendency is to stress what non-users want to avoid rather than what they seek.

"Negative" reasons for not using drugs. What these teenagers want to avoid above all is the harm that drugs can do to the user. Almost four-fifths mention aspects of damage wrought by drugs. These are psychological, social, physical, legal, and moral.

Often the reference is general—"it would be stupid;" "it could ruin your life." Equally often specific dangers are noted: physical danger—about one in four; fear of getting caught—over one in five; mental impairment—nearly one in five; addiction—one in eight; the possibility of a "bad trip" and its recurrence—nearly one in ten; the possible effects on one's future children—about one in ten.

The facts show certain drugs could cause permanent damage to the mind and body. Not many people would want to ruin their life just for a few kicks.

. . . These [bad] trips are like nightmares. You see bugs crawling all over you, walls ready to cave in, a stampede of animals coming straight at you.

A very few correspondents (six) report fear that drug use might lead to a life of crime.

"Positive" reasons for not using drugs. The leading "positive" reasons given for non-use of drugs by teenagers relate to *strength and security*, psychological and social. The non-users, according to about one in three of the correspondents, are the ones who have inner strength, who have goals, who are busy with interesting or worthwhile things.

> . . . But the biggest reason I believe is they like life like it is, and not a fantasy of life.

A sense of identity or autonomy in non-users is mentioned by about one in four. Teenagers who do not use drugs are described as not "needing to be different;" they "already know who they are."

> I want to be me, not just another drug user.

A similar proportion give credit for drug resistance to family and social supports. Parental example, prohibitions, and disapproval are mentioned, as is "a good family life." Equal emphasis is put on the role of "good friends who aren't on drugs." Good families and friends are seen as protections from the pressures that drive young people to drugs and as strong influences in resisting an impulse toward drug use.

> All of us [report of 12 friends] have been offered drugs or come into contact with someone who uses them. It is up to the individual's standards whether he uses them or not. In other words, it depends on your parents and friends, the people who influence you.

Moral or, occasionally, religious principles are mentioned by about one in eight.

> A person who really loves God will love his fellow man, will take on responsibility rather than shun it.

Equal mention is devoted to a preference for "other kicks," described as far more "rewarding and REAL." "Other forms of renewal" and "other ways of relieving pressure" include athletics, dramatic clubs, hobbies, enjoyment of the arts, walks in the countryside, "marching for peace."

> . . . We haven't felt [drugs] necessary because we have been trying to do something about the things which we feel are wrong today. We have marched for peace, campaigned at conventions, negotiated on high school campuses, and hoped for results.

"Neutral" reasons

Several reasons for drug use or non-use can be regarded as "neutral" in the sense that they do not represent an impulse to move toward or away from something.

Substitute for alcohol. About one in eight of our correspondents report that young people seek in pot what others seek in alcohol. Some of them say pot is preferred over alcohol because it is less "harmful," does not cause a hangover, is "cleaner," or "a lesser evil." Such comments are often accompanied by expressions of disgust for adults who freely indulge in drinking or cigarette smoking and then object to teenagers smoking pot.

> Don't sit in front of him with a cancer stick (cigarette) in your mouth and a glass of liquor in your hand and tell him not to smoke pot. Who is to say that your cigarette and liquor won't kill you before his pot will kill him.

But there is a contrasting resentment that in some communities drugs are much easier to obtain than alcohol.

> To buy liquor you first need a draft card as proof and then must look 18. To get drugs all you have to do is walk up to anyone at school and ask them if they have any idea where to get them. . . .

Availability. A number of correspondents (nearly one in ten) attribute use of drugs to the ease of obtaining them. About the same number attribute non-use to the difficulty of obtaining them. Both groups are saying that use or non-use of drugs is influenced by the degree of their availability.

> It is really surprising . . . how easy it is to get. All you have to do is walk out into the park . . . and you get all kinds of offers . . . . If you know the right people you could get some hashish or marijuana in about five minutes.

> One . . . boy announced he had LSD for sale right in the middle of a classroom.

The cost of drugs. Four Youth Reporters give as a reason for drug use that teenagers have too much money. However, others (nearly one in eight) report that the high cost of drugs deters young people from using them.

> Also the price is very high for these drugs. For a small pill of acid which is the same size as a baby aspirin, it costs $10 or more. For 2 oz. of pot it costs $5.

Ignorance. About one in 20 attributes the use of drugs to lack of knowledge about their harmful effects and about legal penalties for using them. However, statements that most teenagers do know about the dangers of drug use are far more frequent.

Counter-points. Most of the points made frequently are contradicted by at least a few reporters. For example, one in twenty Youth Reporters denies that drug use is prompted by a desire to escape.

> I am sure that the old "escape reality" bit is a lot of boloney

Several doubt at least one of the other frequently given reasons—rebellion, conformity, social pressures, curiosity, desire to be tough.

. . . In many cases I suppose the user himself doesn't know why he's doing it.

Do's and don'ts

Nearly every correspondent suggests ways to decrease drug use. These fall roughly under three headings: (1) legalization of drugs: (2) education and persuasion: (3) other programs. Over half the correspondents say directly, and many others imply, that adults should engage in such efforts.

The suggested question "Should adults take steps to discourage the use of drugs . . ." really got me. Is the adult generation so scared of upsetting youth or doing anything they think will give the youth something else to be upset with them about?

However, almost one in five advises parents not to attempt persuasion or influence because they will only stimulate resistance and rebellion.

To legalize or not. Although they were not questioned about this point, nearly half the correspondents report opinions either favoring or opposing legalization of drugs. Of these, about half favor legalization of pot and a few of hard drugs, and about half oppose legalization of any drugs.

The main reason for favoring legalization of marijuana is its alleged harmlessness, in itself, or in comparison with alcohol and cigarettes.

. . . I guess since cars, alcohol and things like that that can be dangerous are legal, we have to have anything else that can damage added to the list.

A very few reporters suggest that legalization of hard drugs would decrease their use because it would discourage "pushers," who "would not be getting rich on it," and the "rebellion" would be eliminated. They also maintain that drugs would be less contaminated, and crimes committed to get money for drugs would be reduced.

Those who would legalize at least some drugs call present laws archaic, inconsistent, and "stupid," especially in their failure to differentiate between different kinds of drugs and in meting out sentences to people who "are sick and need help—not a jail cell." A few also maintain that present laws are ineffectual—"the overwhelming majority [of users] have not been caught by either authorities or parents."

Several reporters point out that favoring legalization does not mean favoring drug use: "rather it would be a step toward minimizing drug use if combined with other methods."

Any crackdown on illegal entry of drugs should start with the hard drugs and work down. Attempts to eliminate, say, marijuana, without first eliminating the more dangerous drugs drive the users of marijuana to, say, heroin.

Many of those favoring legalization imply that penalties for smoking pot should be reduced, if retained at all, some of them specify that penalties for the use of harder drugs should not be reduced. Those opposing legalization are more inclined to stiffen present penalties, especially for hard drugs.

Reasons against legalization include the argument that it would increase drug use just as alcohol use was increased by repeal of prohibition; that marijuana may be an unrecognized health hazard "like cigarettes;" that young people should be protected for their own good.

Most people are sensible enough not to use drugs, but the small percentage who are not smart enough to realize the harm drugs cause should be protected.

Consumer vs. supplier. Bitterness against profiteers also emerges in connection with law enforcement. A few (about one in 14) vehemently urge that there be more differentiation between those who use drugs and those who sell them. Let the police crack down on pushers, smugglers, they say, and one correspondent adds, on the big drug companies that "ship vast quantities of dangerous drugs to Mexico" that are then shipped back to the American black market. A few recommend the death penalty for "pushers."

. . . The government should stop playing around with busting up "pot parties" here and there and crack down on these Mafia and underground groups that are getting rich on messing people up.

What to do

Aside from recommendations concerning legalization of drugs, the suggestions about what to do to diminish drug use tend to be vague and general. Nine out of ten correspondents suggest education and persuasion. However, the fact that nearly half manifest some degree of acceptance of marijuana indicates that these suggestions often—though not always—refer to hard drugs only.

The most frequent suggestions are for school programs—courses, films, speakers, and in a very few instances, the inclusion of parents in such programs. Next come community programs or seminars.

I, myself, have been tempted. Why? Curiosity. Nobody shows us the terrible results that become of drug users. You hear of them, but never see them. I wish we could have a course in drugs, but no one will be bothered.

A few correspondents recommend that public service spots and documentaries be carried on television to have the same "gut impact" as the "cigarettes—they're killers" campaign of the American Cancer Society. Some (one in eight) refer to an educational effort that had a definite deterrent effect on themselves or their associates—a talk given by a former addict, a television or radio program, a journal article, a visit to a rehabilitation center.

The reason that drugs is a bad subject around our school is because of the good movies we have seen through the various classes. They actually make you sick to look at . . . .

Favorable comments on educational programs experienced are twice as frequent as derogatory references such as "teachers talk but who listens?" or "the students know more about the effect of drugs than the instructor."

How to do it

While opinions about what to do are for the most part vague, comments about how to do it are specific. There is real conviction in the following frequent warnings: (1) that advice and instruction must come from the right sources; (2) that the emphasis must be on facts, evidence, and experience; (3) that emotional exhortation must be avoided.

The right source. Over one in three correspondents say that unless information and education about drugs come from the right person, they are likely to be futile. The "right person" is variously described as one who is able to listen to and communicate with young people; who "really cares;" who is trusted and respected, and who "knows what he is talking about."

With regard to age, opinions differ. A few insist on youth in "the right person," but the descriptions most often imply that experience, information, attitude, and approach are more important than age. Parents, teachers, counselors—if they meet the specifications noted—are included, as are physicians, social workers, town officials, policemen, and former addicts. However, one or two advise "no cops."

Facts, evidence, experience. The strongest emphasis seems to be placed on the demand for facts. Don't preach, these young people advise, don't exhort, don't get emotional, don't tell us what to do and what not to do. Just give us the facts and let us make up our own minds. Moral precepts, warnings, or orders are "ridiculous."

Proof of harms of drugs should be shown to them. Not just saying "Don't take drugs." This is wrong. People must be shown why not to for it to be effective.

Parents and peers. A substantial minority of the correspondents rule out parents as effective anti-drug-use educators, but a more substantial minority rule them in, indirectly if not directly.

If parents are good parents, they say or imply, their children "will choose the 'no-drug' route for themselves." Parents should give love and understanding, be aware of their children's associates, teach them that drugs are "not exciting but dumb," set a good example, teach their children "how to face the world and its problems;" and, if they do discuss drugs, should know what they are talking about, according to these Youth Reporters. Moreover, parents should refrain from putting pressure on young people to achieve. Furthermore, they should work to right the social wrongs that make people seek escape through drugs.

Drugs are a problem which may never be solved completely. But perhaps, if the parents of the child show understanding, maybe the youth will not be so apt to escape. If his life is good, he will not need the artificial thrills. . . .

Some young people not only deny that parents have a role in discouraging drug use but award them an important place in promoting it—sometimes by example, more often by failing in their parental role.

The importance teenagers attach to peer groups is evident in these reports, especially in the strong emphasis they put on status and conformity as reasons for drug use and on peer influence and lack of peer pressure as reasons for non-use. The general assumption seems to be that if either the family or the peer group exercises a very strong force, it can prevail over the other.

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ADOLESCENCE, IDENTITY, AND FOSTER FAMILY CARE

J. MCEWAN MACINTYRE

In the United States, on any given day, a quarter million children are living in foster family homes; about half of them will probably spend a major part of their childhood years in foster care. In addition to having to cope with the emotions aroused within themselves by being sent away from their own families, these children are faced with the need to get along with a new set of parent figures and perhaps also with a new set of brothers and sisters, new neighbors, new teachers, and new classmates. When such a drastic change takes place in adolescence, it comes at one of the most critical stages of development. The way it is handled may be crucial to the young person's future relationship to himself, to other persons in his life, and to society in general.

To appreciate the kind of double crisis facing adolescents in foster care—the developmental crisis of adolescence itself and the personal crisis of being uprooted and transplanted into an unfamiliar human environment—one needs an understanding of Erik Erikson's concept of identity, a concept that Erikson has clarified and expanded over the years since he first introduced it in 1950.[1-6]

Erikson's theories are an extension to the psychological sphere of the biological concept of epigenesis. Epigenetic development is characterized by a series of sequential stages, each of which must appear in an orderly sequence and in a definite rhythm of growth for optimum adaptation during the entire life cycle. In his theory of personality (or ego) development, Erikson presents the first psychoanalytic theory to encompass the total life cycle as a progression from infancy through early childhood, preadolescence, adolescence, adulthood, maturity, and senescence. His underlying assumptions are: (1) that the human personality develops according to steps that are predetermined by the growing person's readiness to be driven toward, to be aware of, and to interact with, a widening social radius; and (2) that society attempts to meet and invite this succession of potentialities for interaction and to safeguard and encourage the proper rate and the sequence of their unfolding.

Erikson describes eight stages in the life cycle, each characterized by the necessity of resolving a specific developmental crisis, a task that must be accomplished to some extent before the individual can proceed to the next stage. While admitting that complete resolution rarely, if ever, occurs during the critical stage, he presents his theory in the hypothetical extremes of successful and unsuccessful resolution; for example, the development of basic trust or mistrust. The word "crisis" is not used in the conventional sense, rather it indicates characteristic critical points, the resolution of which lead the personality on to further progress and integration, or, if unresolved, to regression.

Identity formation

Erikson perceives identity formation as evolving throughout childhood and adolescence through synthesis and resynthesis of the sense of self into a configuration that gradually integrates "constitutional gains, idiosyncratic libidinal needs, favored capacities, significant identifications, effective defenses, successful sublimations, and consistent roles." [2] Such a configuration derives from "a process of simultaneous reflection and observation . . . by which the individual judges himself in the light of what he perceives to be the way in which others judge him," while he regards their way of judging him "in the light of how he perceives himself in comparison to them and to types that have become relevant to him." This process is unconscious for the most part, except in situations in which "inner conditions and outer circumstances combine to aggravate a painful or elated 'identity-consciousness.' " [6] At its best, identity formation is a process of increasing differentiation that becomes ever more inclusive as the individual grows aware of a widening circle of other people who are significant to him—all the way from the one maternal person to "mankind."

The sense of identity that the person gains is "the accrued confidence" that one's ability to maintain inner sameness and continuity is matched by the sameness and continuity of one's meaning for others. Thus self-esteem, affirmed at the resolution of each major crisis, becomes "a conviction that one is learning effective steps toward a tangible future, that one is developing a defined personality within a social reality which one understands." At each step in his developmental process the child must "derive a vitalizing sense of reality from the awareness that his individual way of mastering experience is a successful variant of the way other people around him master experience and recognize such mastery." [3] The dominant developmental goal is for "the active selective ego" to be in charge and to be "enabled to be in charge by the social structure." [5]

Erikson's identity concept is focused on the fusion of the elements of identification, capacity, ideals, and opportunity into a viable self-definition. The assembly of all these elements is a formidable task for an adolescent. If this task is not accomplished, he faces the danger of identity confusion or identity diffusion—the failure to establish a sense of self-worth. At adolescence, development involves processes of identifying with persons significant in one's life and with ideological forces. These processes together give meaning and importance to individual life "by relating it to a living community and to ongoing history, and by counterpointing the newly won individual entity with some communal solidarity." [5]

While identity formation does begin long before the adolescent years, the adolescent must achieve a complicated task of synthesis. He must relate his earlier identifications with his own personal qualities as he now assesses them and to the social ideals and the opportunities available to him. What the youth is to become—in the sense of strength of personality—is influenced by what his environment has permitted and now permits and encourages, and his own talents, needs, and defenses.

Problems of foster care

How then can adolescents in foster care accomplish their developmental task?

Erikson maintains that to achieve a feeling of identity—or inner solidarity—a young person must gain "a sense of inner continuity and social sameness which will bridge what he was as a child and what he is about to become." [2] Most adolescents go through some inner turmoil while struggling for this goal. How much harder then must it be for foster children whose childhood has been disrupted by removal from their homes and perhaps again from one foster family to another? No wonder many of them have trouble incorporating their past and present experiences into an integrated picture that suggests the possibility of constructive, satisfying experiences in the future.

Numerous studies have shown that children in long-term foster care usually experience two or three placements and that the more placements they have experienced, the more problems they present.[7-10] Other studies have shown that the length of time in foster care also is related to the incidence of behavior problems, but that this incidence is less among children whose own parents maintain contact with them.[11, 12] Such findings suggest that when a child's parents keep in touch with him, the child's feeling of having been rejected is lessened. Studies have shown that when a foster mother exhibits a hostile attitude toward the child's own mother rather than accepting her as a significant person in the child's life, the probability of the child's doing poorly in the foster

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home is increased.[13] Apparently the child needs to have repeated assurance from his own parents about his background so that he can perceive himself in relation to his parents and in relation to himself at an earlier age.

In her follow-up study of adults who were foster children, Elizabeth Meier [14] gives clear evidence that the removal of children from their own homes has a negative effect on their ability to form an adequate sense of identity, especially if the children are boys. Her data on the men in her study suggest that when a boy spends a major part of his childhood away from his own family, the resultant damage to his self-image may make it difficult for him later as a man to maintain a marriage or carry on successfully in the world of work. The young women in Meier's study seem to have done better, judging by their ability to perform their roles as wives and mothers. The data suggest that the quality of their experiences in foster care was of greater importance in their development than the fact of having been in foster care. The members of both sexes, however, demonstrated a lesser sense of satisfaction than their achievements would seem to warrant. Most of them gave no evidence of having a feeling of "inner assuredness," which Erikson regards as indicative of an optimal sense of identity.

Maas and Engler found abundant evidence that children who move through a series of families or are reared without close and continuing ties to a responsible adult have more than the usual problems in discovering who they are.[8] Such children tend to develop only shallow roots in relationships with others; they try to please others, but cannot trust them, or they strike out against others before they can be let down. For these children the environment has not been consistent enough to allow them to construct a coherent picture of positive relationships. Their ability to trust others is impaired to the point of hampering the development of their own trustworthiness. Because of frequent fundamental changes in their lives, they are unable to build a sense of inner sameness and continuity.

Erikson suggests that a wholesome concept of self includes recollections of the past, awareness of present realities, and expectations of the future. Parents generally think about their children as growing individuals who will one day be young men and women. They remind the children of this frequently, they promise the children future privileges, and they urge the children to do certain things *now* in preparation for future demands. Thus the children gain a sense of continuity.[5] The foster child, however, may realize that neither his foster parents, his social worker, nor any other responsible adult in his present experience expects to be a continuing part of his life in the future.[14]

Even when there is no overt trouble in the foster home, the continuity of the child's experience may be at risk, for changes in circumstances may occur within the foster family—illness in the family, pregnancy of the foster mother, or the arrival of a relative, such as an aging parent who needs the child's room. Pointing to such contingencies, Elizabeth Glover described the foster child's status as having "a potential lack of stability." [15]

Implications for service

In spite of these hazards to identity formation, foster family care is necessary for thousands of children and will continue to be necessary for some children whether or not important improvements are achieved in services to prevent family breakdown, to maintain family health and income, or to provide better housing, all measures that could conceivably reduce—but not eliminate—the need for foster care. This prospect raises the question: "How can foster care promote, rather than impair, the foster child's sense of identity?"

This question has special relevance for the child whose foster care is prolonged, for he is the child whose ability to achieve a strong sense of self is most likely to be impaired.

The following five suggestions, none of them new, are worth renewed emphasis:

1. *Avoidance of replacements whenever possible.* This requires adequate decisionmaking at the time of the first placement. Such decisionmaking, in turn, may require:

- *Participation by the child* insofar as possible, as well as his parents, not only in the decision to place, but also in the type of placement to be made. Adolescents particularly may be more amenable to the placement if they feel they have had some say in the choice, or at least, that their opinions have been solicited and respected.

- A look at a *wider variety of living situations* than is customary among many child welfare agencies. A few agencies, for example, are beginning to recognize the following possibilities: (1) *the establishment of agency-owned and operated small group homes* housing four to six children or adolescents under the care of foster parents who are full-time, paid employees of the agency; and (2) *the wider use of middle and upper-class families* as foster parents of children who are unlikely to be returned to their own parents.

In Washington, D.C., for example, the Family and Child Services has employed a number of couples to care for four or five children each in houses bought or rented by the agency.[16] In this type of arrangement, foster parents, regarding themselves as permanent employees of the agency, are more likely to weather the ups and downs of a child's reactions to separation from his parents and to work closely with the agency in his behalf. As a result, the child may be less likely to sense a shaky balance of mixed feelings on the part of those who care for him and so may feel more secure. Some authorities have suggested that it may be "a mistake to think that love and money are mutually exclusive; particularly if the need for money can be linked with a third important motive, pride in doing a job well."[7]

At least one agency has experimented, with some success, in aiming a campaign to recruit foster parents within relatively affluent groups,[17] but such efforts are rare. While child welfare workers usually look to upper middle-class families for adoptive homes, they generally do not regard such families as resources for the foster care of children. Nevertheless, as Annette Wigod has pertinently noted, "Disadvantaged children require—and deserve—the most nurturant, the most restorative environment our affluent society can provide."[18]

2. *The maintenance of parent-child relationships.* Even though a child or adolescent does have to be removed from his own home, he should be afforded opportunities to see his parents regularly, unless circumstances indicate that his own protection demands the termination of parental rights through court order. If the child is placed in the same community in which his parents live, he can visit in his home and also maintain relationships with some of his friends from his home neighborhood and school. Another means of helping adolescents maintain or regain relationships with their own families might be through the use of "halfway" foster homes that would allow them to spend weekends, holidays, and other special occasions at home with their own parents.

There is some, but not very much, recent literature on continuing work with the parents of foster children with a view of achieving a possible reconciliation with their children.[19, 20] Many parents have no contacts with the child-placing agency after placement, or even with their placed child. Because few agencies exert much effort in trying to strengthen the parents' ability to function as parents, many children who might otherwise be happily reunited with their families spend their childhood in foster care. Perhaps many parents cannot be helped to become more responsible or effective parents because the social work profession lacks the knowledge or skill to help them, but perhaps, too, more parents could be helped if the child-placing agency would raise its sights to encompass a view of the parents' needs as well as of the child's. In reaching a placement decision with a child's parents, the agency needs to make clear its expectations that they are to have regular interviews with a caseworker and to make plans for the child's possible return home.

3. *Education of the foster parents in principles of child development.* Foster parents might help children retain and develop further their sense of identity if they understood the process of identity formation and the importance of roots for the child. With such understanding they would be less likely to take a disapproving or hostile attitude toward the child's own parents—attitudes that can be devastating to the child's sense of self-esteem no matter what troubles he has had with his parents. More and more agencies are using one-to-one supervision, group meetings, and special courses to help foster parents and prospective foster parents understand the special needs of children in foster care.[21-22] At least one agency has made arrangements for adolescents who are in foster care to attend meetings of prospective foster parents to tell them what it is like to be a foster child.[23]

4. *Group meetings of adolescents in foster care.* Giving groups of youths in foster care a teaching role in the preparation and education of foster

parents heightens their own self-esteem.[23] The same may be true when adolescent or preadolescent children discuss their problems together. A growing number of agencies are sponsoring such discussions.[24-26] Helen Northen, in discussing the group as a problem-solving medium, tells of how one group of foster children worked on problems of "identity, adequacy, and attitudes toward other people" by discussing their views of how their foster parents felt about their parents, the reasons their parents were unable to care for them, and their uneasiness at living with strangers.

5. *Giving each foster child a dossier of material about himself and his family.* Meier has suggested this step on the basis of her finding that discontinuities in experience not only cause emotional problems but also deprive the child of the supports that help him know "who he is in relation to other persons, where he has been when he has been at different places, and what has happened to him at different times in his life." She suggests including in the dossier information about the foster child himself and where he was born, his mother's and father's full names, names of relatives he has known, addresses where he lived prior to being in foster home care, names and addresses of foster parents with whom he has lived, pictures of himself at various ages, pictures and letters from family members, report cards, and such other "accoutrements of this age of paper which are used to record the human being's progress through life." [14] Thus the child would have a kind of super identity card.

The task ahead

"A new era in fostering has unfolded." says Mike Grant, a member of a group of adolescents who drew from their own experiences in interpreting foster children's needs to foster parents.[23] Perhaps child welfare workers, who carry the awesome responsibility for child placement and eventual family reunion, will draw from these bright words renewed determination to help children and teenagers find strength rather than despair in the experience of foster care.

Erik Erikson, in describing the process of identity formation and its critical importance in adolescence, gives an indication of how complex this task can be.

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PAT AZARNOFF

A PLAY PROGRAM IN A PEDIATRIC CLINIC

Today many hospitals in this country provide play programs for hospitalized children as an important part of medical treatment. However, only a few pediatric outpatient clinics in the United States provide any activity programs for children and very few of these are conducted by paid staff members.

The experience of the child activities program at the outpatient pediatric clinic of the University of California at Los Angeles illustrates some of the important benefits that such a program can provide.

As the director of the program, I am responsible for arranging the environment, planning the activities, and training volunteers to play and talk with the children. I speak with parents about their children's behavior, accident prevention, toy selection, criteria for choosing a nursery school, and general health information. I also observe patients in spontaneous play to pick up diagnostically important information for the staff.

The basic purpose of the program is to make it easier for the child and his family to come to the clinic and to create an atmosphere in which the child is trusting enough to be cooperative. But there are many byproducts of benefit to the clinic's operations as well as to the child and his family.

In addition to couches and cushioned benches, the clinic's waiting room contains an area furnished with child-sized tables and chairs, small animals and fish, blocks, toy trucks and cars, books, and equipment for playing house. An outdoor play yard, fenced-in and grassy, offers a hill to climb or roll down, a large log for climbing on, a sandbox, tricycles, wagons, a small doll house with miniature furniture and bendable dolls. There are also benches placed under sun umbrellas to encourage parents to be with their children outside. Each of the examining rooms contains a shelf of toys, books and magazines, dolls and blocks.

Instead of sitting fearfully while waiting their turn to be seen by a doctor, or climbing over furniture, upsetting parents, and being noisy or destructive, the children can play with toys and equipment selected to interest them. The pleasant physicial surroundings help calm their fears of the medical setting and prepare them to cooperate with the staff. As a consequence, there is less need for the children's parents and the clinic's staff members to spend time controlling misbehavior.

The children often test their ideas about their illness or about the hospital with us.

Susan, 5 years old, told us, "The doctor is going to check my heart today. I had heart surgery. He's going to see if it's still beating, I think."

A 4-year-old girl who had just had a blood test reported, "They made me bleed. They took all my blood." After we sympathized, we gave her a few other ways to consider what had happened.

A 9-year-old boy told us the doctors were going to get "pictures of his health" (X-rays) and maybe he was "dead inside."

We offer the patients and their families nonmedical experiences with the staff, a person-to-person contact in which the child has the chance to give or control the situation. For example, the children distribute popcorn that we make in a popper in the waiting room. Around holidays we make small gifts in craft sessions for each child to give to his doctor or nurse. Or we bake cupcakes and decorate them. The surgeon carves our Halloween pumpkin. The inhalation therapist pumps helium into the

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Based on a paper presented at the 1970 convention of the American Association of Child Care in Hospitals.

balloons or punchbag. The gardener asks the children's help in watering the flowers and sweeping the yard.

Diagnosis and training

Members of the medical staff are encouraged to watch the children at play in the waiting room and yard, especially those who are about to be examined. The information obtained from the staff's observation adds a dimension to the diagnostic process and the decisions about therapy.

A physician examined a 10-year-old boy whose arm cast had recently been removed. The child, who had been advised to exercise his arm, had reported that he was using it extensively now. Afterwards, in observing the child at play outside, the physician noted that the boy unconsciously favored the other arm. The physician joined the children's ball game and showed the boy that it was not necessary to guard the arm any longer.

The staff psychologist, who was especially interested in children with school phobia, asked us to put a child, who seemed to be upset about the psychometric testing, in the play area with friends of his own age. The boy visibly relaxed. Soon afterward he returned to the testing situation less fearful and able to perform better.

Students of medicine, psychology, education, special education, nursing, and social work are also given scheduled opportunities for observing and interacting with the children, to improve their interpersonal skills and their knowledge of normal growth and the effects of illness or chronic disability on a child's development.

Screening and prevention

Conversations with parents in the waiting room can result in important preventive measures with the patient. A mother may have brought along other children who may show signs of acute illness or chronic conditions that have not been reported. Or a parent may mention a child left at home because "she was too sick to come to the clinic."

Noting that a 5-year-old girl being held in her mother's arms seemed unusually weak and listless, I asked the mother if she had brought the child in to see the doctor. Shaking her head, the mother said that the appointment was for her son, not her daughter, and that she had made it several weeks before. When I told her that her daughter could be seen immediately by a physician in the Walk-In Clinic, she was obviously relieved. On examination the little girl was found to have a fever of 104 degrees.

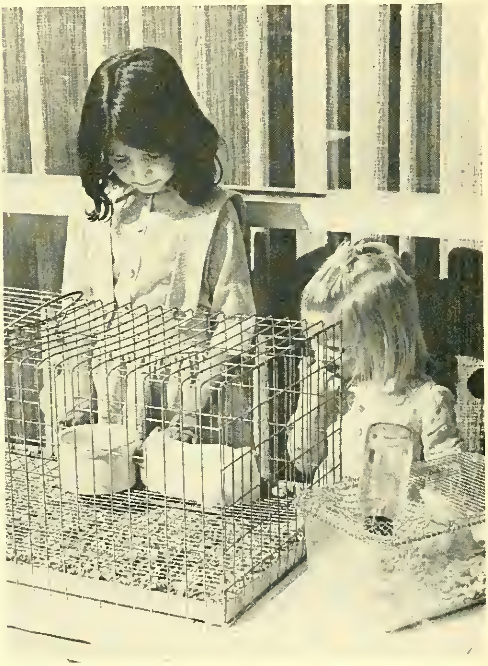
After watching us manage disruptive behavior in the clinic, parents will sometimes ask me about ways to handle their children's temper tantrums or other difficult behavior. In such instances I let the parents know that the doctor would be interested in discussing the problem with them.

A child may be so active that the mother is exhausted, but she believes that the child's behavior is the result of her faulty attempts at discipline. Perhaps her parents or husband have been blaming her, too. When this kind of hyperactivity is observed while the child is at play, a neurological examination follows and medication may be prescribed.

Parent education

Many of the families who use our clinic come repeatedly. We get to know them well enough to

A guinea pig in the children's waiting room of UCLA's Outpatient Clinic attracts the attention of two young patients.



talk informally and easily together when questions come up. Our bulletin boards display easy-to-read health information in both English and Spanish. A mother engrossed in reading a magazine, for example, may not notice her toddler playing with the ashtrays, tearing up magazines, or jumping from the furniture. When we bring the mother a toy to offer to her child, we are not only preventing possible difficulties at the moment but also making ourselves available in case she wishes to talk about the child.

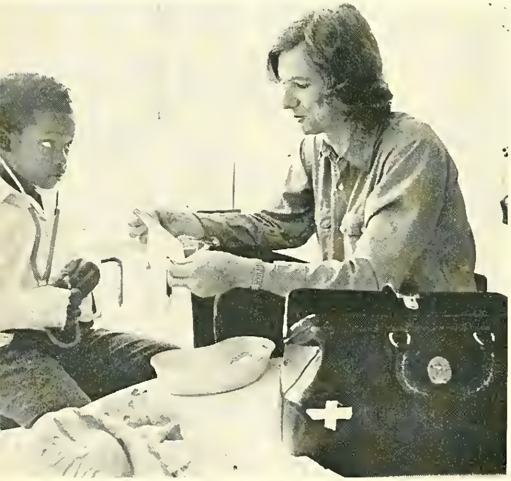
The mother may say, "I guess he is playing with the cigarettes, but nothing we ever give him keeps his attention." We may suggest the substitution of safe toys for unsafe objects. Instead of picking up ashtrays and playing with the ashes and tobacco, the child can have a shoe box of sand or sawdust. Instead of turning lights on and off, the child can have a flashlight.

Parents who stay in the play area with their children can learn how their children behave with other children, or can discover simple games and crafts to try at home.

Because play is a natural activity for children, the play area is ideal for demonstrating points about child behavior to parents.

A mother who was concerned about the "hyperactivity" of her 2-year-old was sent by the doctor to the play yard so she could see her own child next to others. After watching other 2-year-olds moving the toys around, failing to put things back where they belonged, and always being "on the move," she seemed to understand better the relation of behavior to the natural process of growing. We talked about the possibility of rewarding the curiosity of her child and setting limits on the kind of behavior that must be controlled.

With the help of a clinic volunteer, a child uses a stethoscope "just like the doctor" to listen to his beating heart.



We use many homemade toys and equipment not only to keep within our budget, but also to offer parents models that are easily duplicated at home. We show the children how to plant seeds, such as grapefruit, orange, or apple seeds or kidney or lima beans. On return visits to the clinic, children are encouraged to take home the plants that grew from the seeds they planted.

The children decorate oatmeal boxes from the hospital kitchen to make drums that they can take home. They cut pictures from magazines, paste them on cardboard, and then cut them into pieces to make puzzles. A decorated carton that a toddler can climb in and out of is always available.

Besides demonstrating these easily made items, we talk with parents about the possibility of getting their children longer-lasting toys such as tricycles, child-sized kitchen furniture, or dress-up clothes, dolls, trucks, and construction toys.

We also use the children's behavior at play to involve parents in discussions of appropriate behavior.

One mother allowed her 3-year-old child to throw toys at other children and to bite others when he was angry. The mother had read that children need outlets for their anger. There was no time to talk with the mother first. We stopped the behavior by diverting the child's attention to something else. Then we talked with the mother, discussing other possible outlets for anger and the importance of looking for its causes.

Child care

Most clinics know the problem of cancelled appointments. Sometimes the problem arises because at the last minute the mother did not have a place to leave her other children. In our clinic a mother can bring her other children along without being overwhelmed by the necessity of keeping them out of mischief while trying to talk to a staff member about the child brought in for medical attention or just waiting his turn to be examined. The volunteers in the child activities program will help her care for the other children. In helping parents, by changing diapers, feeding babies, or watching active children, the volunteers always take the lead from the parents as to how much help or what type of help they want. The parents are encouraged to do as much as they can themselves and to use the volunteers' assistance when needed.

When social workers, psychologists, or physicians wish to speak with a mother alone, especially after a diagnosis of a difficult nature, or because extensive explanations are needed, her children are sent to the play area. There they are supervised until the mother returns for them.

Because of the importance of parental visits to the morale of a hospitalized child, the outpatient play area is also made available to parents who need some place to leave other children while visiting a child on the inpatient ward. This not only makes it easier for parents to visit their hospitalized child regularly, but it also provides the staff with an opportunity to help these other children understand what is happening to their hospitalized brother or sister. With the parents' permission, we talk with these children individually, gently correct their misconceptions, and so ease their fears.

We also inform the parents of hospitalized children about the privilege of bringing their other children to the weekly picnic held in our play yard for inpatients on the children's ward. Thus the hospitalized child and his brothers and sisters have a chance to visit with one another.

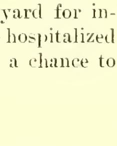
Public relations

In most clinics there is a waiting period between the time the patient and his family arrive and the time he actually sees the doctors or undergoes the procedures scheduled for him. It seems a paradox to offer high-quality medical care, but provide a waiting room atmosphere that fosters poor mental health. Lines of hard benches, poor lighting, no available food source, no play area for children are not attributes of excellence of care. Moreover by discouraging clinic attendance, they prevent children from getting the care they need. Many parents have remarked that they bring their children to our clinic because they know that when they get there someone will care about how comfortable they are, and the atmosphere will be conducive to health, not tension.

In the play corner in the pediatric clinic's waiting room children re-create some of the everyday events of home life.

A child activity program is only one type of auxiliary service pediatric clinics could offer. In our clinic we are beginning to offer some others: teaching child care to older children who are left in charge of younger children in the waiting room; providing health education to the community through films, slides, tours, and talks; holding discussion groups for parents, teenagers, and siblings of chronically ill or mentally retarded patients; and developing health manpower through training volunteers and students. Many of these efforts are offshoots of the child activities program.

With a clinic staff interested in the psychology of illness and crisis, with administrators willing to provide the necessary salaries, space, and budget, and with a volunteer program available to recruit, screen, and continuously train volunteers to help, a child activities program can show its worth. This is being demonstrated every day at the UCLA pediatric clinic.



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CHANGING PROSPECTS FOR CHILDREN WITH HEMOPHILIA

KENNETH M. BRINKHOUS

Until recently the chances of a child afflicted with a severe case of hemophilia living to adulthood without serious crippling, or having a normal life if he did so, were slim. This hereditary disease of uncontrollable bleeding afflicts mainly males. Made famous by a strain that runs through the royal families of Europe, it has meant for its victims pain, crippling, the necessity of repeated hospitalization for blood plasma transfusions, and constant threat of death from bleeding into the brain, air passages, or other vital organs. It has also brought its victims severe social and psychological problems, stemming from their inability to lead normal lives.[1, 2] Now, however, the prospects for the hemophilic child are much brighter because of a revolutionized method of care made possible by the recent development of blood plasma concentrates.

With early diagnosis, prompt treatment, and proper management, life-threatening hemorrhages in hemophiliacs can become a thing of the past. A few boys and young men who have hemophilia are already receiving the plasma concentrates prophylactically for the prevention of hemorrhage, much as the diabetic receives insulin. The concentrates must be given by intravenous injection. This treatment has completely changed the way of life for its recipients. They now can attend school, play, go to work, and live much like normal males of the same age. The life expectancy at birth of a hemophilic child—once estimated at 18[3]—may now approach that of normal boys.

But many problems still stand in the way of a normal life for most hemophilic children. A continuous alert for the occurrence of hemorrhages and their prompt treatment must be maintained. Moreover, supplies of plasma concentrates are limited and expensive; it is not unusual for a child with hemophilia to use plasma concentrates costing $12,000 a year.

How many persons there are in this country with hemophilia is unknown. Estimates range from between 10,000 and 15,000 for those with severe forms of the disease up to 100,000, including all who may have a mild form. Many mild bleeders are unaware that they have hemophilia until major surgery or a serious accident reveals deficiency in the clotting of blood. The National Hemophilia Foundation estimates that 40,000 boys and men in the United States have moderate or severe forms of the disease.

The disease

Hemophilia is a disease of males, inherited through the mother, in whom the blood plasma lacks a specific trace protein that produces clotting. The two main forms, hemophilia A and hemophilia B, cause similar symptoms. However, they differ in the specific types of clotting protein that is missing in the blood.

Hemophilia A occurs five or six times as frequently as hemophilia B. The general impression among physicians is that hemophilia B is not as severe as hemophilia A. Patients with hemophilia A seem to require hospitalization and transfusions more frequently than those with hemophilia B.

Both types of hemophilia show up in the same way. The baby boy with hemophilia may bleed excessively when the umbilical cord is cut at birth or after he is circumcised. Parents notice "black and blue" marks and bruises on the infant's body. When the child starts walking and running, troublesome and persistent bleeding into the large joints causes painful swellings, especially of the knees and elbows. Once a joint has been the site of a severe hemorrhage, recurrences of bleeding in the joint are frequent.

Bleeding episodes may occur after mild trauma; many, however, may occur unpredictably. The possibility of serious internal bleeding in one form or another haunts the hemophiliac throughout life.

Problems of impaired emotional and social development often arise in the school-age hemophilic child because of his irregular attendance at school and overprotective environment at home. These problems often carry over into adult life. Such problems may later be reflected in the adult hemophiliac's social adjustment and ability to hold a job.[1, 2] With the birth of a hemophilic child, the whole way of life of a family can be greatly affected. This is dramatically demonstrated in Massie's recent best seller, *Nicholas and Alexandra*,[4] which depicts the effect of the young czarevitch's hemophilia on the course of Russian history.

Methods of inheritance

Both A and B types of hemophilia stem from genes that follow a sex-linked pattern of inheritance according to Mendelian law. The male inherits the disease through his mother, who carries the gene for hemophilia but is otherwise normal. There is no father-to-son transmission.

The hemophilic gene is located on the X-chromosome, one of the two chromosomes that determine sex. The other is called Y. A child with two X-chromosomes, XX, is a female: if one of her X-chromosomes carries the hemophilic gene, she is a carrier of the disease. A child with one X-chromosome and one Y-chromosome, XY, is a male: if his X-chromosome carries the hemophilic gene, he will have hemophilia.

A female carrier, with one affected X-chromosome, is protected from the disease by the accompanying normal X-chromosome. Geneticists can predict the average composition of the families of both hemophilic males and carrier females by sex and hemophilic status. For example, a man with hemophilia married to a normal woman will have all carrier daughters and all normal sons. A woman carrier of hemophilia married to a normal man could have four children distributed as follows: a normal daughter, a carrier daughter, a normal son, and a hemophilic son.

In small families the distribution of children by sex is often very different. Hemophilic men may sire only two children, both sons. In this case, there is no transmission of the disease to later generations. Women who are carriers may give birth to three children—all sons, all with hemophilia. Conversely, while a carrier may have three normal sons, such a remarkable event would probably go unrecognized, since the carrier status of the mother would likely not be known. Only if she also has a carrier daughter who eventually gives birth to a hemophilic son would the true situation become apparent.

Some progress has been made in detecting the carrier state in women before the appearance of a hemophilic son. A laboratory test has been developed to measure the amount of the clotting protein or antihemophilic factor in the blood. Women with hemophilic children have been found on the average to have only half as much of the clotting protein in their blood as do their normal sisters.

Laboratory testing, however, involves several problems. The test itself is difficult and expensive to carry out and requires special laboratory equipment. Even with reliable laboratory results, accurate interpretation of the test is not easy. One pitfall lies in the fact that not all carriers have a 50–50 distribution between blood cells that can and cannot produce the clotting protein. For example, if a woman has only a few cells that cannot produce the antihemophilic

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protein, the level of the clotting factor in her blood is in the low normal range although she is a carrier. Also, the use of birth control pills may increase the amount of the hemophilia A clotting protein in the blood of some women, which could further complicate interpretation of the test.

A family history of hemophilia, combined with laboratory testing for low levels of the clotting protein in the blood, provides the most reliable basis for predicting that a woman is a carrier. Many women who have been tentatively identified by laboratory tests as carriers of hemophilia have later confirmed the diagnosis by giving birth to a hemophilic son. At the present time, however, screening the general population of women to find carriers of hemophilia is not feasible.

Some women have given birth to hemophilic children although there was no history of hemophilia in their families. In fact, roughly one-third of the families with hemophilic children are in this category. How did they become carriers? There is no simple explanation. Some of these persons are undoubtedly mutants—that is, their mothers were not carriers, but one of their own X-chromosomes was changed in some unknown manner. On the other hand, with small families the hemophilic gene can be submerged in the genetic pool for long periods of time and a family line may not have a hemophilic son for many generations. Before the potential seriousness of the hemophilia problem is assessed for a woman identified by laboratory tests as a carrier, the findings need to be correlated with her family history.

Many men have a mild form of hemophilia that is not troublesome except at times of operations and accidents. If correctly diagnosed, the mild disease can be readily managed medically. Female carriers of the mild form show low levels of clotting protein in tests, just as do carriers of the severe disease.

Family planning in hemophilic families presents special problems. Limitation in family size is the rule followed by most families once the disease appears. The prediction of carriers can be of real value, by alerting the family early in pregnancy to the possibility of hemophilia.

The liberalized interpretation of abortion laws in many States, combined with application of present knowledge of genetics, offers a means of reducing the hazard of hemophilia in affected families. As a first step the sex of the unborn child must be determined. Early in fetal life this can be done by amniocentesis—the surgical process of tapping the uterus for a small amount of amniotic fluid in which the fetus lives in the pregnant woman. Two methods are used to analyze the fluid: (1) cell culture, which determines whether the sex chromosomes are XX (female) or XY (male); or (2) more simply, the test for the Barr body, a characteristic that is present on the nuclear membrane of female cells.

In families in which the father has hemophilia, if only the males were allowed to come to term, the transmission of the hemophilic gene to a daughter who would be a carrier to later generations would be stopped. If the mother is a carrier, the choices are less clear cut. By having only daughters, she at least avoids the hazard of giving birth to hemophilic sons. In any event where abortion is not prohibited by law, the decision would have to be made on a purely voluntary basis by the parents themselves, after full discussion with their physician.

Development of treatment

That blood transfusions have a corrective effect on hemophilic bleeding has been known for over a century. The first transfusion was given in London in 1840 to a hemophilic boy who was bleeding from an operation to correct a squint in one eye. By modern standards the procedure was crude: a few cubic centimeters of blood at a time were withdrawn from the donor and injected directly into the patient. No anticoagulant was used. The bleeding stopped. But with surgery on other hemophilic patients, the bleeding continued in spite of treatment with blood transfusions.

The effectiveness of transfusions in treating hemophilia was a matter of medical controversy for nearly a century. Physicians who found transfusions effective could not agree on what part of the blood was responsible for clotting—the platelets or the plasma.

In 1947, in research laboratories at the University of North Carolina, we were able to show clearly that the active antihemophilic principle resided in the plasma.[5] We also demonstrated that the antihemophilic factor was well preserved only as long as the plasma was frozen. We made the first application of this observation in our treatment of hemophilic dogs in 1949.[6] Hospital and community blood banks quickly put our findings to use, and fresh frozen plasma became the mainstay in the management of hemophilia for more than 15 years.

Fresh frozen plasma made great improvements possible in the treatment of hemophilia. While it still has a place in treatment today, frozen plasma has serious shortcomings. The main problem is that normal plasma has such a low concentration of the clotting protein that relatively large volumes are needed to control hemophilic bleeding. Bleeding is not always effectively staunched by this treatment. Moreover, injection of such large amounts of plasma often results in an excessive volume of circulating blood and leads to acute congestive heart failure.

The need for a plasma concentrate that would correct clotting has long been recognized. Preparation of antihemophilic material from animal and human blood was first attempted more than 30 years ago—even before the nature of the active principle of hemophilia was known—but with little success. No advances were made until the antihemophilic factor was identified. Then in 1952 the two types of hemophilia were separated; hemophilia A and B were recognized as separate entities that needed distinctly different clotting proteins for treatment. At the same time laboratory studies produced a suitable procedure for identifying and assaying the antihemophilic factor for hemophilia A. A basic procedure known as the partial thromoplastin time test was developed in our laboratory and is now commonly used for assay and diagnosis of both hemophilia A and hemophilia B.

Many concentrates for hemophilia A, the more common type of the disease, have been developed. Their potency is indicated in two ways. One way is the degree of *purification* of the antihemophilic protein, expressed as the ratio of the antihemophilic activity to the total proteins in the concentrate. The other is the *concentration* of the protein in solution as it is ready to be administered to the patient.

We have divided these concentrates into separate generations, similar to the generation classifications used for missiles, to indicate relative stages of development.[7]

Generation I consists of the first concentrates to be developed, which had low potency. The generation I materials were often less concentrated than normal plasma.

Generation II concentrates are purified 10 to 100 times. When made into solution ready for administration to the patient, they are five to seven times more potent than the same volume of normal plasma.

The development of generation II concentrates was made possible by two discoveries.[8] One was the finding by Robert H. Wagner at the University of North Carolina in 1962 that glycine could be used to separate the clotting factor from blood plasma by precipitation. Concentrates of the antihemophilic factor precipitated in this way were used to treat hemophiliacs in the period from 1962–68. The superiority of these concentrates to fresh frozen plasma was striking; hemorrhages and bleeding that previously would have been judged to be catastrophic or fatal for hemophilic patients were rapidly brought under effective control.

The second discovery utilized the low solubility of the clotting protein at freezing temperatures, which was first observed in the 1950's. Judith Pool and associates of Stanford University in 1964 found that the precipitate that remains undissolved when frozen plasma is thawed slowly at icebox temperatures can be used to stop bleeding in hemophiliacs. The scientists developed a procedure by which blood banks can collect this material in concentrated form, called cryoprecipitate. This material has largely replaced fresh frozen plasma, and since 1966 has provided the primary mode for treating hemophilia. However, cryoprecipitates as made in blood banks have some disadvantages: their preparation is time consuming and their potency, which varies greatly between units, cannot be determined easily.

The latest developments are generation III or

A boy with hemophilia receives antihemophilic concentrates, a recently developed material used to prevent as well as treat the massive bleeding episodes characteristic of this disease.

high-potency concentrates made by combining several procedures used in preparing various generation II concentrates. The main advantages of the generation III concentrates are that their potency is high and their exact strength is known. High potency means that only a small volume of fluid is needed for treatment and it can be administered simply by syringe. The known high potency of each vial gives this concentrate a particular advantage over cryoprecipitates. At present, however, the supply of the generation III concentrates is small and the only one generally available is the one we introduced in 1968.[7]

Because exact bio-engineering for the control of hemophilic bleeding has become a reality with the generation III concentrates, a medical team can bring patient's clotting ability to normal in a matter of minutes. With the use of the concentrate, major surgery can be carried out on a hemophiliac without bleeding. In contrast to the preconcentrate days when simple tooth extraction was a major medical and dental procedure for a hemophiliac, today full mouth extractions in a hemophiliac are carried out with no excess bleeding.

Concentrates for hemophilia B became available in this country in 1969. The general problems with bio-assay, isolation of the hemophilia B protein, and translation of scientific findings to a practical therapeutic product paralleled those encountered in developing concentrates for hemophilia A. In certain respects, however, the work with hemophilia B concentrates was somewhat easier because the material is more stable.

A fuller description of the advances in the treatment of hemophilia can be found in the book "Hemophilia and New Hemorrhagic States," which was written by scientists and physicians who have been significantly involved.[9]

It would be a boon indeed if the clotting mechanism of persons with hemophilia could be permanently normalized. One way to accomplish this might be by transplanting from a donor the organ responsible for the manufacture of the antihemophilic protein. But what organ to transplant? Many attempts to identify the organ that produces the antihemophilia A factor have been unsuccessful.

Early studies from our laboratory pointed to the spleen. But in most laboratories in which spleen transplants have been carried out in hemophilic dogs, this procedure did not succeed in correcting the bleeding tendency for more than a few days. This failure may have been due in part to the dogs' rejection of transplanted spleens. However, the experiments suggest that the spleen is a storage depot for the antihemophilic factor rather than the manufacturing site. Our studies then shifted to the kidneys and the liver. Hemophilic dogs seem to have been cured of their disease following liver transplants, but they have lived for only a few weeks or months after the operation. Although research is continuing, transplantation appears to be a long way from becoming an available therapeutic tool for permanently correcting hemophilic defects in humans.

Strategy for the future

With the many advances reported here, it might seem that the problem of hemophilia is well under control. Actually, this is far from the case. Concentrates have improved the lives of hemophiliacs inestimably. But the hemophiliac still requires treatment and close medical attention throughout life.

Use of concentrates in the prevention of hemorrhage appears to be the best approach to the disease, because it eliminates the cost of hospitalization and assures the hemophiliac that he is under hemostatic control. To be most effective, injections with cryoprecipitate are needed daily: injections with high potency concentrates are needed several times a week. Most of the antihemophilic concentrate used today is prepared individually in blood banks. Although 5 to 10 percent of the resources of all blood banks in the country are channeled into the management of this relatively rare condition, the supplies of concentrates—especially those used to treat hemophilia A—currently are inadequate for a preventive program for the entire hemophilic population. Because of the shortage of concentrates, hospitalization will continue to be a common experience for the hemophilic child faced with a severe hemorrhage.

We need to find more effective methods of preparing the antihemophilic factor and to obtain a substitute for the scarce human product. Although animal materials have been produced in the laboratory, they are not in widespread use because they cause hypersensitivity and adverse protein reactions in human recipients.

Prompt transfusion at the first indication of hemorrhage is still vital in treating a hemophilic child. With the increased availability of blood products, transfusions can be done in the doctor's office, the outpatient department of a hospital, or in the patient's home if a member of the family has been trained in the transfusion procedure.

Organization of medical care for the hemophiliac has improved greatly as new discoveries have been made. About 50 specialized hemophilia centers have recently been developed in hospitals in the United States for the care of patients with serious hemorrhages, surgery, management of the complications of hemophilia, and attention to social problems. Multidisciplinary teams—including hematologists, clinical pathologists, orthopedic surgeons, psychiatrists, dentists, social workers, physical therapists, and other specialists—provide diagnosis, continuing comprehensive care, and rehabilitation. The hope for the future is that by prophylaxis and prompt and adequate treatment for each bleeding episode, serious and crippling hemorrhages will occur less and less frequently, and the need for the hemophilic child to travel repeatedly to specialized centers will be greatly reduced.

Hemophiliacs need improved health insurance. Obviously individual families cannot bear the tremendous financial burden brought on by hemophilia, which might well be classed with the "dread diseases." Under a means test based on the costs for treatment of a child with severe hemophilia A, most families in America would be considered medically indigent.

Some State crippled children's services provide treatment for children with hemophilia, but most of them do not have enough money to pay the full cost for families who cannot pay anything or even to make up the difference for families who can pay part of the cost. The same is true of Medicaid. Obviously, attention needs to be given to the special problem of the hemophiliac when methods are revised for the delivery of and payment for medical care of the chronically ill.

Family planning services and information are needed for families with a history of hemophilia. When families become aware of the many social problems related to hemophilia, they are more likely to consider therapeutic abortion as an alternative to the birth of a hemophilic son. Even so, the large number of mutations and the skipping of generations in the appearance of the disease make the elimination of hemophilia in future generations unlikely. Realistically, the goal of the National Hemophilic Foundation, public health and rehabilitation workers, and other persons interested in hemophilia is to reduce the birth rate among affected persons to the greatest extent possible.

While many problems exist for the hemophiliac today, the tremendous advances in the past 20 years should not be overlooked. Crippling has decreased, the need for hospitalization has decreased with modern treatments, and large numbers of hemophiliacs are growing up to become well-adjusted, contributing members of society. These advances are the direct result of laboratory, animal, and clinical research. The struggle of man to uncover Nature's secrets continues. Successes on the research front will be reflected in continued improvement in the treatment of the victims of hemophilia.

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Why can't the doctors, nurses, parents, treat kids more like humans? Don't they think we don't know or will understand? Why can't they explain? . . . When a kid is 10 to 15 he ought to know the score of the show if he is one of the characters. . . .

A young hemophiliac as quoted by Alfred H. Katz in "Hemophilia: A Study in Hope and Reality." Charles C Thomas, Springfield, Ill., 1970.

FOSTER FAMILY SERVICES FOR MENTALLY RETARDED CHILDREN

BEATRICE L. GARRETT

A year ago the President's Committee on Mental Retardation issued a report that challenges community planners, persons in the helping professions, and lay citizens alike to develop a more adequate range of resources for mentally retarded children than presently exists. Such a range of services the committee saw as necessary for achieving the "programing goals" of integrating the child into normal community living and enabling him "to develop his ability and potential to the fullest possible extent . . ."[1]

The most important resource for achieving such goals are services to enable mentally retarded children to develop within their own families. However, some children cannot be cared for at home, and for them a major resource is foster family care.

Foster family service can provide the child with an opportunity to become a part of the community. It can also provide him the kind of individual, loving attention that in many cases has helped mentally retarded children realize unsuspected potential.[2] Whether a child who cannot be kept at home is placed in foster family care or an alternative resource must, of course, be based on the individual needs of the child and his family. Experience has shown, however, that most children, especially younger children, thrive better in a family setting, provided the family has an understanding of their needs and how to meet these needs.

Foster family care is distinguished from group care and institutional care by its smaller size (six or fewer children in the home unless they are all siblings), by being community based, by age differences in the children, and by the family living pattern. In States that require foster families to meet standards for licensing, the use of overcrowded foster homes—or what amounts to small institutions labeled as foster homes—can be avoided.

Used appropriately, foster family service often results in more progress and less misery for the mentally retarded child. It may also save money, but how much can desirably be saved is questionable. One study has indicated that foster family placement of 24 children saved a State $200,000 in one year.[3] The question is, however, whether the program *should* have saved that much money. Were the foster families not sufficiently reimbursed or the children's special needs not met?

Because of the many advantages of foster care for children who must be away from their parents, many institutions and child welfare agencies today are attempting to increase and improve foster family services for mentally retarded children. In doing so they are often confronted with many difficult problems.

Concepts for programing

The President's Committee on Mental Retardation has identified two concepts for working with the mentally retarded that can be valuable as guides in evaluating, improving, and developing foster family service for mentally retarded children. These concepts have been called "normalization" and "human management."[4]

Normalization refers to designing programs for mentally retarded children so that they will—

1. Enable the child to behave in a way that will lead others to perceive him as not too different from other children—or at least as little different as possible.

2. Help others see the child's strengths and similarities to other children so that his differences from others will be minimized.

3. Help people in general gain a broader perspective of what is normal and acceptable in child development.

Four interrelated and inseparable principles, derived from the normalization concept, apply to foster family service:

- *Integration*—promoting opportunities for the child to interact with others in the community. This goal can best be achieved for the child who can adjust outside of a group situation when he lives in a normal community with a family that uses the community's resources in the usual ways.

- *Dispersal*—placing no more foster children in each community than can be absorbed and integrated into community life.

- *Specialization*—developing a team of social caseworkers, mental retardation specialists, and foster parents with knowledge and skill in fostering the potentials of children who have problems of development and acceptability.

- *Continuity*—ensuring the continuing involvement of the child's own family in his life through opportunities for interplay between the parents and the child as long as this is useful for the child.

The human management concept applies to the parents of the mentally retarded child as well as to the child himself. It has three main requirements:

- That the child's parents be regarded by the helping staff as normal persons under unusual stress, and not be "denormalized" by being regarded as different from other parents.

- That, with rare exceptions, the foster family be used only to supplement and not supplant the role of the child's own family. Next in importance to maintenance of life for the child is maintenance of his place within his family.

- That decisions regarding structure, policy, and individual problems be measured by whether they best meet the individual needs of the parents and child, not by whether they promote medical, institutional, or program "efficiency."

Provision of service

Today foster family services for mentally retarded children are provided under various auspices—specialized institutions, State and local child welfare agencies, voluntary child welfare agencies, and different combinations of these. In a recent study of intake of public and voluntary child welfare services in seven cities, 5.2 percent of the children served had IQ's below 75. Seventy-nine percent of these children were served by public agencies.[5]

If medical, psychiatric, psychological, or other specialized services the child needs are available for diagnosis and treatment, the retarded child is usually better served through the existing community-based child welfare agency than through an institution or clinic far from his home. The community-based agency that has a comprehensive service for children and their families can help parents decide whether they can keep the child at home or whether the child should be placed in an institution in another community or in a nearby group home or foster home.

An agency can improve its services to mentally retarded children by assigning a staff worker as an ombudsman (or advocate) for such children. The ombudsman will consistently hold the agency to its commitment to meet these children's needs.

Regardless of whether the service to mentally retarded children is provided through a community-based agency or an institution that develops a foster family service, the quality of the service is dependent on clearly spelled-out plans for coordination with other resources. The expertise, knowledge, and resources of both the institution or agency specializing in service to the retarded and the agency specializing in foster family services are required. For instance, a State institution for mentally retarded children may, after an interagency planning conference, enter into a written agreement with a county child welfare agency to provide diagnostic evaluations for a mentally retarded child while the county agency works with the parents and provides foster family services.

Coordination between community resources is also important for staff training. The concepts, knowledge, and skill that social workers have developed to help other children and their families are, of course, basic to foster family service to the mentally retarded. But work with the retarded requires additional knowledge about the meaning of mental retardation to children and their families as well as special skill in dealing with their problems. Agencies need to plan ways of helping their workers achieve the necessary knowledge and skill. The specialized institution or clinic may be the best resource for teaching social workers the unique aspects of such work. Child-caring agencies sometimes arrange for an exchange of workers to achieve such training. Some agencies also assign all cases involving mental retardation to workers who handle only this type of case and who thus have an opportunity to sharpen their insight and skill in helping the mentally retarded.

Indications for use

Foster family care has several advantages over institutional care for a child, especially one whose retardation stems from emotional deprivation or lack of stimulation rather than from organic causes, for such functional retardates are likely to thrive in a normal family environment: (1) it does not set the child apart; (2) it provides social, emotional, and developmental experiences through close, continuing relationships with parent substitutes; (3) it provides a greater chance for development along socially normal lines through day-to-day interaction within a family and community; and (4) when the child is placed in his home community, it makes it easier for the members of his own family to keep in touch with him. Placing the child near his own home is especially important when the plan calls for his eventual return to his family.

Foster family care is not suitable for the child who, because of severe behavior disturbances, may be dangerous to himself or others when not in a controlled environment. Children who require specialized medical treatment not available in the community may also need institutionalization. Some institutions have developed satellite foster family programs so that children can have the advantages both of family life and specialized medical care.[6]

Retarded children may be placed with foster families for various reasons: (1) to give parents time to deal with the psychological impact of learning of their child's retardation and to come to a considered decision about care of the child; (2) to give a family temporary respite from the strain of caring for the child; (3) to learn through observation whether the child has hidden potentials; (4) to provide the child with a family experience preliminary to eventual institutionalization; and (5) to provide part-time care (for example, 5 days a week) or care during the family's vacation.

To be of real value for a child, foster family placement should be selected specifically to meet the child's needs. It should not be just a holding action to serve until institutional space becomes available. Careful selection of the right home, continuing supervision of the child, and support for the foster family tend to prevent the harmful experience of replacement. Placement is effected preferably through a voluntary agreement signed by the parents, but in many instances it results from a temporary or permanent court commitment.

Work with parents

Foster family service has four main components: the provision of social service for the child's own parent; the provision of social service to the child; recruitment, supervision, and education of the foster families; and development of cooperative working arrangements with community resources.

Parents of mentally retarded children needing foster family service come from all socioeconomic levels. The service to parents begins when the possibility of placement is first brought to the agency's

Beatrice L. Garrett, Children's Bureau specialist in foster family care, last wrote for *Children* on "The Rights of Foster Parents" (May–June 1970). A member of the Children's Bureau staff since 1962, she was previously executive director of the Child and Family Services of Knoxville, Tenn. She has also worked in the Family Service Society of New Orleans. Her master's in social work is from Tulane University.

attention, whether directly by the parents or through a referral from an individual, a court, or another agency. The service is focused on helping the parents make and follow through with the kind of decision that is most likely to be helpful to their child and one which they can live with comfortably. In helping parents come to a decision, the medical practice of using the least drastic treatment applies. This leads to the following order of priorities for consideration: (1) maintenance of the child in his own home; (2) placement in an adoptive home; (3) placement in a foster family; (4) placement in a group home; (5) placement in an institution.

The decision on treatment is most appropriately made on the basis of careful multidisciplinary study and diagnosis of the specific persons involved and the specific situation, rather than on a general statement of priorities or rules and regulations. For example, consider a 5-year-old child whose mother will never be able to make a home for her because of a chronic illness. The accepted priority would be to plan adoption for the child, but the social study establishes the fact that there are strong ties between mother and child. Therefore, the decision is to place the child in a permanent foster family and arrange for regular visiting between mother and child.

Parents have a right to service both as persons in need of help and as parents of a mentally retarded child. All parents who are considering placing their child away from home are experiencing a crisis in their lives. However, parents of a mentally retarded child must deal with a crisis of special severity. In recognizing their child's retardation, they have sustained an agonizing blow to the ego. They are often torn by ambivalence and are dreadfully confused. They cannot help but feel depressed and devaluated. They may feel guilty. Their defense may lead to rigid denial and "shopping around," to masochistic commitment to the child, or to complete inability to cope.

Such parents need a reliable relationship with someone who is competent to help them, who can give them—whenever they feel the need—personal acceptance, warmth, emotional support, information, guidance, and practical methods for dealing with their problems. They need continuing help in working through their grief before, during, and after the child is placed. A social worker can provide this service through one-to-one conferences, interviews with the whole family, group meetings for education or treatment, and referral to other resources.

The social worker must be alert to the often contradictory feelings of parents in order to help them arrive at a sense of security in their decisions and decide how they can handle the spoken and unspoken questions of their other children, neighbors, and relatives.[7]

The development of a careful social diagnosis, tentative prognosis, and recommended treatment, and provision of supportive services are the work of a multidisciplinary team. Beside the social worker, this team may include pediatricians, psychiatrists, psychologists, child development specialists, nurses, speech therapists, nutritionists, physical therapists, and others. To secure the services of such a variety of disciplines, many agencies have to depend on special clinics and institutional staff.

When the time is right, the social worker uses the team's recommendations, as well as its findings concerning both feeling and tangible facts to involve the parents in weighing alternatives. The parents need time in making their peace with the chronic problem facing them. After the initial crisis that brought them to the agency, they need to feel that an agency, preferably the same one that made the placement, is available to help them when new problems arise.

Many parents are more able to accept institutional care than foster family care. They and their neighbors see the institution as a medical facility that provides special services not available to them at home. They can more easily justify this to themselves and others than they can justify placing their child with a family unrelated to them.

The child

Mentally retarded children for whom foster family care is considered vary greatly. They may be in early infancy or in late adolescence; passive in temperament or hyperactive and hostile; in good physical condition or handicapped by complicated physical defects or medical problems. Their retardation may be regarded as profound, severe, moderate, or borderline. They may look strange or be normal in appearance. In many children the retardation may stem from deprivation rather than organic impairment.

In all mentally retarded children there are both similarities to, and differences from, other children. In many of these children the differences result in problems that place extra demands on community resources, on parents, and on foster parents. These problems require different degrees of care and service, ranging from total physical care to specialized vocational training.

Of significance in foster family placement is the likelihood that the mentally retarded child will be slower than other children to adjust to new people and new places. He needs more preplacement preparation—more retelling of the what and why of placement, and more preplacement visits to the foster family's home. If at all possible, he should be accompanied by his parents on the preplacement visits and at the time of placement. If the child is living in an institution, he may need to be visited by the foster parents several times and then to be taken home with them for a number of overnight stays before being placed in their home.

In working with the foster parents, the social worker can use the child's reactions to the preplacement visits to help the child express his feelings and to answer his spoken and unspoken questions. How the parents, the caseworkers, and the foster parents handle the actual placement and the child's feeling of loss at being separated from his parents will greatly affect the child's future sense of identity.

For example, the child whose sense of time is limited and who has difficulty in understanding where his parents are if they are not present, may lose all conception of who he belongs to unless the verbal explanation is reinforced by visits.[8]

Mentally retarded children have certain characteristics in different degrees, for which foster parents need preparation and continuing help. These include: lack of interest in the environment, lack of affectionate response, slowness to learn, inability to communicate feelings or relieve anxiety through verbal expression, rocking and head banging, repetitive behavior, pica, resistance to change, resistance to routine and habit training, slow development of independence and self-help, flightiness or short attention span, hyperactivity, unevenness in ability, memory problems, and apparent immunity to pain. Such characteristics are often sources of frustration and confusion for foster parents.

Foster parenting

Foster parents of mentally retarded children need the same qualities as foster parents of other children, but they need some of these qualities in an unusual degree. All foster parents need to be in basic marital agreement and to have physical and emotional stamina, the ability to love the child as he is, and the ability to work with the agency and to grow in their vocation. But foster parents of mentally retarded children need some qualities in an unusual degree—patience, confidence, readiness to set up expectations that are tailored to fit the child's individual needs, optimism and an ability to receive satisfaction from small gains, to tolerate frustration and "endless" repetition and to allow the child to be dependent as long as needed without losing sight of ways to help him grow toward self-dependence. They also need a secure feeling of acceptance by their neighbors and by others who are important to them.

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The agency can support foster parents through one-to-one supervision and through educational group meetings at which various types of specialists in mental retardation can help them achieve greater understanding and skill in working with the child. The agency can also help foster parents recognize and deal with the child's feelings and capacities; know how much to expect from the child; use toys to encourage motor activities; and help the child understand feelings aroused by objects and people and prepare him for things to come.

The agency may also help foster parents examine their own feelings about the child's own parents and recognize the child's need to express his feeling of loss and separation from his family;[9] learn how to help the child develop a self-image through the use of everyday devices, such as mirrors and pictures; set up and consistently enforce a few rules and routines in accordance with the child's needs; and find ways for the child to do some things successfully, praising him for his effort as well as for his successes.[10] But even more important than developing those techniques, foster parents need to know how to help the child feel loved, enjoyed, and valued.

Of great importance in foster family service is the availability of the special resources the child may need at different stages in his development. What about medical facilities offering expertise in problems of mental retardation? Do the schools provide suitable instruction for mentally retarded children with a minimum of separation from other children? Are there facilities for vocational training and a sheltered workshop for the teenage youth? Are there camps, day camps, "Y's" and other recreation facilities that make provision for these children? Is there a day-care center or nursery school that may be used to stimulate the child and to give relief to the foster parents? What is the neighborhood attitude likely to be toward the child who has a different way of developing? Can the foster parents be helped to handle negative reactions and teach neighborhood children to play with the child? Foster parents need to know about such resources and how to use them.

The process of recruiting and selecting foster parents for mentally retarded children begins the preparation for the important job of foster care. It is a teaching process that must continue on a planned basis throughout the period of service.

If mentally retarded children are to be provided with foster care, the community needs to know about their need for foster parents. This requires a year round recruitment program presented in a down-to-earth way that points up the contribution foster parents can make without glossing over the difficulties of caring for a mentally retarded child.

In spite of the difficulties, foster parents can be found for children of all levels of retardation. For example, of 36 foster parents interested in caring for retarded children, 44 percent said the level of retardation did not matter to them; 25 percent said their interest stemmed from previous close contact with a mentally retarded person; and 25 percent said they had accepted retarded children because they were asked to meet a pressing need. Fifty percent said fostering of mentally retarded children was a job for which they should be paid.[11]

Many more foster parents are likely to become available and to continue in service when agencies institute certain modern administrative practices for all but permanent foster families. These practices include: full reimbursement for the actual costs of keeping the child; provision when needed of agency-owned or rented houses, in some instances especially equipped for children with handicaps; regular relief help; homemaker service; and a reasonable salary for the foster parents plus the same fringe benefits available to other agency employees.

Some propositions

In summary, I present the following propositions arising from the concepts of normalization and human management for consideration by persons who have a responsibility to plan for or serve mentally retarded children:

1. When a child cannot be cared for at home or placed for adoption, foster family service should be the preferred method of care unless the child obviously requires another form of care.

2. At the time the child is diagnosed as being mentally retarded, especially a child from a disorganized family, the diagnosis should be tested by providing him with an emotionally enriching and stimulating family and community living experience.

3. A community-based comprehensive child welfare service is the best means for providing a foster family service for mentally retarded children *if* it accepts this responsibility and makes administrative provision for such a program.

4. Foster family service for mentally retarded children of all socioeconomic levels, as for other children, must include counseling for the child's parents as well as service for the child.

5. The foster parents should be employed by the child-serving agency, be paid a reasonable salary with fringe benefits in addition to the costs of foster care, and be provided with sequential educational opportunities for increasing their competence in serving the child.

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an essay review

THE CONCERN OF ONE GENERATION FOR THE NEXT

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History has given us a number of reports of cultures in which children have been reared to become ideal citizens of the State. Plutarch, for example, described how Lycergus dictated the communal living of young Spartan boys to foster the development of attachment and loyalty to each other so that he might have a magnificent army. In his book "Two Worlds of Childhood,"* Urie Bronfenbrenner has become a modern Plutarch by analyzing his brilliant studies of child-rearing patterns in the U.S.S.R. In contrast to Sparta, in the Soviet Union there is obviously not only a concern for children themselves, but also a major investment of resources, manpower, and community interest in rearing the healthiest and best functioning children possible. As one Russian authority has explained, "It is not true that we have a classless society. Children are our privileged class."[1]

In contrast to the other mammals, the human young when they complete the first round in personality development—which they do chiefly within the family—are still not ready physically or mentally to take a place in the adult world. Instead, they then go through what Benjamin Spock has called a "middle-age period of childhood." In this period the child learns, through group participation and exploration, about the characteristics of the segment of the world around him, its makeup, patterns, expectations, rules, and value systems.

Bronfenbrenner, who has studied the Soviet school system and child more intensively than any other "outside" scientist, details how the Russian school program uses this developmental pattern of group formation to guide character formation, emphasizing loyalty to the group above the individual and stressing group achievement and enforcement of correct behavior. His thesis is that in the United States the lack of a comparable systematic approach has led to increasing problems in our educational institutions and communities.

Different approaches

Actually the pictures cannot be so definitely contrasted. Both systems (if the American pattern can be called a system) have their successes and their failures. However, the Soviet approach unquestionably prevents most of the culturally determined mental retardation seen in this country. It creates the climate for and expectation of community involvement, responsibility, and participation. It also seems to have resulted in less juvenile delinquency, although there are recent reports of increasing delinquency in the U.S.S.R.

One cannot argue with the underlying Soviet concept that the teacher of the young is one of the most valued contributors to the good of the country and should be selected, trained, and paid accordingly. However, the American goals for the ideal individual citizen are quite different from the Russian, emphasizing as they do self-reliance, independence, and self-sufficiency, as well as patriotism and team spirit. What is missing in the American approach is the dedication and the resources poured into the "upbringing" process that one sees in the U.S.S.R. It is estimated that in 1967 our Federal Government spent $190 per child in contrast to close to $2,000 per older citizen, even though there is increasing evidence that much of the health and adjustment of later life has its roots in appropriate health care and experience in early childhood. Our expenses for the elderly are too late for righting many of the deficits created by neglect and disregard in the first 3 to 5 years of life.

There is a slow but growing awareness around the world about the importance of appropriate care and experience in the first years of life to the individual's later development. Recognizing this fact, the Soviets for a while began providing a group living experience in infancy in an attempt to make optimal development possible for all children. Bronfenbrenner points out that the Soviets then found that family experience is of crucial importance and that there is no real substitute for the basic mother-infant closeness and affective interaction and so modified their practice.

However, the U.S.S.R. is asking itself a question the rest of the world must consider: "Is there not so much for the developing human to learn and be prepared for in an increasingly technologically oriented universe that we can no longer leave early experience only to the family, but, long before the child reaches school age, must add group education and experience to what the family provides?" The Soviet's answer is the provision of "infant upbringers" for a network of infant schools. These "upbringers" are usually well trained and highly regarded as representatives of a new professional type of community resource.

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*TWO WORLDS OF CHILDHOOD. Urie Bronfenbrenner. Russell Sage Foundation, New York, N.Y. 10017. 1970. 185 pp. $7.95.

Soviet psychology and psychiatry have placed major stress on the influence of the environment on behavior and character development. This emphasis underplays, or even discounts, individual differences in constitutional makeup, in the belief that desirable molding can be accomplished by appropriate training and early group experience. This point of view has its Western counterpart in the recent preoccupation with behavior shaping through "operant conditioning."

A serious omission

These approaches to child-rearing and learning disregard the "inner life" of the child, a component which is beginning to be acknowledged and considered in the U.S.S.R.[2] Bronfenbrenner takes cognizance of the importance of this component only as he describes the warmth and intensity of the Russians' early mother-child relationships as a necessary precursor of the child's ability to be effectively attached to a group. But from there on he gives the child's inner life little consideration as he describes the influences of such forces as social reinforcement and modeling or shaping the behavior and moral responses of the individual child through appropriate guidance of group pressures and group responsibility. He reveals a possible new trend, however, by quoting Novikova, the Soviet child development authority: "We have to discover how to create the kind of collective which will insure the most full and many sided development of each person."

What evidence do we have about the eventual outcome of these child-rearing approaches? Precious little, unfortunately. A somewhat facetious and quite unscientific reply was given to President John F. Kennedy by a member of his Panel on Mental Retardation who reported on a committee's investigations of Soviet child-rearing patterns. The President asked, "Does it work any better than ours?" The answer was, "We don't really know, but we did a small research study with young Moscow taxi drivers who are not supposed to take tips. Fifty percent of them do."

What are the goals?

What should be our goals in the development of our children? What should we prepare them for? Must we not think of their readiness to function in relation to the realities of the world around them?

Rapidly, "the world of childhood" is becoming the whole world. The forms of violence as carried out in Asia, Africa, or Chicago are brought by television into every American living room. Are Soviet children better off for not being exposed to instant replays of guerilla warfare or replays of the devastation wrought in Hiroshima?

Are our children fascinated by violence on television because they are attempting to learn how to cope with the violence around them? Are some of them becoming alienated because of the duplicity they see between countries and blocs as well as in their own families' dealings with insurance companies or the income tax? Do we say to them, like the Pirate King to Frederick, "Away to the cheating world go you," or do we help them develop better value systems?

We need to help children develop maximum flexibility and ability to move ahead to new solutions for problems instead of "turning off." This means including the new dimensions of today's world in the horizons of our young and the new tools and devices they need to deal with the world as it is and with each other. Encouraging in children the inner freedom to think and act in new ways is not incompatible with the development of good citizenship, a sense of responsibility, and respect for the integrity, rights, and territory of others.

The end result of the Soviet group child-rearing patterns and the American middle-class patterns are similar as far as the parents are concerned. When the school-age child is "turned over" to the peer group, the parents are freer to use their day and leisure time for other purposes. Bronfenbrenner points out the major difference—the Soviet children have much more intensive, guiding supervision from trained and interested adults and more involvement with groups of children older than themselves. He plugs for more supervision and adult involvement with school-age children in the United States than simply the parents' attendance at PTA meetings.

Most of the action Bronfenbrenner proposes centers on the disadvantaged child. With this we obviously can have no quarrel. In fact, we can agree with all his recommendations while disagreeing with his reasons for some of them. For example: Isn't the violence that the slum child sees around himself everyday more influential than the violence he sees on TV? Couldn't the aggressive response of the middle-class child to violence in TV, shown in Bandura's experiments—referred to by Bronfenbrenner—be explained by the well known mental mechanism of "identification with the aggressor?" I am not, of course, recommending overdoses of violence anywhere in the child's life experience.

In the United States we need to give an overriding priority to seeing that the needs of every child for developing properly are known to responsible persons and that the means of meeting these needs are made available, as they are in the U.S.S.R. The concept of a Community Commission on Children, suggested by Bronfenbrenner, would be one means of accomplishing this objective as would the similar child advocacy program recommended by the Joint Commission on the Mental Health of Children.[3] The principle to be guided by is provided by Bronfenbrenner in his statement of his theme, *the concern of one generation for the next.*

In the United States we are concerned, but we are not always aware of what to be concerned about until the child, the family, or the community is hurting. Urie Bronfenbrenner, the roving Professor of Child Development and Family Studies from Cornell, has given us some valuable guidelines.

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BOOK NOTES

DISTURBED CHILDREN: examination and assessment through team process. Staff of the Menninger Clinic Children's Division, The Menninger Foundation. Jossey-Bass, Inc., Publishers, San Francisco, Calif. 1969. 296 pp. $9.50.

In this book, staff members of the Menninger Clinic at Topeka, Kans., describe the interlocking methods they have devised for working as a team in reaching a psychiatric diagnosis for disturbed children brought to the outpatient department. The basic team includes a psychiatrist, a psychologist, a social worker, a neurologist, and a speech and hearing therapist; other specialists are added when necessary.

According to the authors, the psychiatric diagnosis of a child must involve consideration of congenital, gestational, maturational, physiological, neurological, psychological, parental, familial, cultural, religious, and socioeconomic factors. Each member of the team contributes to the development of an integrated, comprehensive diagnosis on which treatment is planned. Parent participation in each step, which is an integral part of the Menninger method, enables the family to understand and accept the diagnosis.

The book includes many case illustrations of the points made in its chapters on the team process in diagnosis; working with parents; evaluation of treatability; the psychologist's contribution; speech, language, and hearing; the neurological examination; the psychiatric examination; the role of conferences; team function and misfunction.

THE WRITINGS OF ANNA FREUD. Volume V: research at the Hamstead Child-Therapy Clinic and other papers, 1956–1965. International Universities Press, Inc., New York, N.Y. 1969. 575 pp. $12.

Volume V in this series of Dr. Freud's works on psychoanalytic theory in relation to child development contains a number of short papers on such subjects as adolescence, emotional and social development of young children, children in the hospital, family law, and the contribution of direct child observation to psychoanalysis. A number of the papers are published for the first time, including "Psychoanalytic Knowledge and its Application to Children's Services," "The Contribution of Direct Child Observation to Psychoanalysis," and "Psychoanalytic Knowledge Applied to the Rearing of Children."

Among the previously published papers that appear in this volume are "The Theory of Parent-Infant Relationship," "Children in the Hospital," and "Entrance into the Nursery School: the Psychological Prerequisites." The volume also includes outlines of applications submitted to foundations to obtain financial support for research, and introductions written by Dr. Freud for books by her colleagues at the Hamstead Clinic.

A FOLLOW-UP STUDY OF ADOPTIONS: post-placement functioning of adoption families, vol. I. Elizabeth A. Lawder; Katherine D. Lower; Roberta G. Andrews; Edmund A. Sherman; and John G. Hill. 1969.

POST-PLACEMENT FUNCTION OF ADOPTED CHILDREN, vol. II. Janet L. Hoopes; Edmund A. Sherman; Elizabeth A. Lawder; Roberta G. Andrews; and Katherine D. Lower, 1970. Child Welfare League of America, Inc., New York, N.Y. $4 each.

These two publications present the results of a research project carried out jointly by the Bryn Mawr College Graduate Department of Social Work and Social Research and the Children's Aid Society of Pennsylvania, with support from the Children's Bureau.

The first volume reports on attempts to answer two main questions: how adequately do adoptive couples adjust to the responsibilities of adoptive parenthood and what information predictive of later family functioning can be obtained before completion of adoption. The second volume reports on an attempt to discover in what ways the adopted child differs from the child reared in his own home and to identify factors predictive of adoption outcome.

The findings reported in volume I were based on questionnaires and personal interviews with 200 families, selected at random from the 556 families in which children had been placed by the agency from 1950 through 1957. The investigators found that at least 70 percent of the parents functioned "average" to "high" on all areas rated except "communication of the fact of adoption."

The most important aspects of family functioning turned out to be degree of parental warmth and affection, satisfaction in the adoption and parental role, and role compatibility in decision-making; a positive predictive factor, the parents' ability to discuss their feelings about infertility during the application process; and a negative predictive factor, excessive criticism of the child by the parents during the supervisory period. Differences in the children were found to be less important to family functioning than the parental factors of warmth and acceptance of adoptive role.

Volume II reports on the development of 100 adopted children, ages 10–15, selected at random from the pool of families previously studied. They were matched for sex, school grade, and social class with 100 children living with their own parents, and compared in relation to intelligence, teachers' ratings on overall school adjustment, and personality, measured by both objective and projective tests. The findings showed no difference between the two groups in intelligence or in personality measures. On teachers' ratings of overall adjustment, 55 percent of the adopted children were rated as "good to excellent," but more control than experimental children were rated as "excellent."

An analysis of the case records showed the capacity of the father to accept infertility bore a relation to his acceptance of the child. The parents' age at time of application was unrelated to the child's later functioning as was their ease of communicating the act of adoption to the child. Again arental warmth and parental role ompatability in decisionmaking outveighed negative factors concerning he child, including the previous depriation.

The authors point out that the reearch population was Caucasian, preominantly Protestant and middle to pper-middle class and that their findngs do not necessarily apply to a diferently composed population or to ndependently adopted children.

HEMOPHILIA: a study in hope and reality. Alfred H. Katz. Charles C Thomas, Publisher, Springfield, Ill. 1970. 159 pp. $9.

This book examines the social, psychological, medical, and employment problems of persons with hemophilia, an inherited male disorder in blood clotting that is marked by episodes of uncontrolled bleeding (see p. 222). After identifying the "key" problem for the parents of a hemophilic child as that of providing necessary physical protection without overprotection, the author warns that too many restrictions can lead to psychological crippling. He cites a survey of adult hemophiliacs, who said they would advise parents to let a hemophilic son live as nearly a normal active life as he could.

Pointing out that the hemophilic child has frequent and prolonged absences from school because of hospitalization or episodes of bleeding that keep him at home, the author suggests steps a local school board can take to meet the special educational needs of hemophiliacs and other chronically ill children. He reports that a relatively large proportion of hemophiliacs have inadequate educations: in a survey of 1,055 men who had the disease, he found that 34 percent had not completed high school.

The author declares that society's lack of knowledge about, and understanding of, hemophiliacs is a basic social problem. In addition to a communications program designed to increase the public's general understanding of the disease and to present a more realistic picture of the hemophiliac, the author recommends reevaluation and extension of rehabilitation efforts, vocational counseling, early detection of adjustment problems followed by appropriate action, parental counseling, counseling of the hemophiliac on problems of life adjustment, genetic counseling, disability insurance, and preplanned hospital care.

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guides and reports

DEVELOPING MENTALLY HEALTHY CHILDREN. Katherine E. D'Evelyn. Introduction by Reginald S. Lourie. American Association of Elementary - Kindergarten - Nursery Educators, 1201 16th Street, NW., Washington, D.C. 20036. 1970. 32 pp. $1.25.

Describes what is necessary in an elementary school to promote the mental health of children.

CHILD WELFARE AND THE COMPUTER: a projection of potential. Dr. Brandt R. Allen and Dr. Alexander B. Horniman. Edwin Gould Foundation for Children, New York, N.Y. 1969. 35 pp. No charge.

Presents a model for computerizing information in the child welfare field.

ETHNIC MINORITIES IN SOCIAL WORK EDUCATION. Edited by Carl Scott. Council on Social Work Education, 345 East 46th Street, New York, N.Y. 10017. 1970. 89 pp. $3.

Contains 10 papers that discuss ways of bringing more students from minority groups into schools of social work and reorganizing the social work curriculum to deal with the problems of racism, poverty, and inequality in America.

HELPING LOW-INCOME HOMEMAKERS: programs and evaluations—a selected, annotated bibliography. Margaret Harding. New York State College of Human Ecology, Cornell University, Ithaca, N.Y. 14850. 1969. 142 pp. $2.50.

Contains digests of 208 reports chosen for their interest to home economists, agricultural extension agents, social workers, and other persons who work with low-income families.

INSURANCE PROGRAMS FOR NEIGHBORHOOD CENTERS: a guide. National Federation of Neighborhood Centers, 232 Madison Avenue, New York, N.Y. 10016. 1970. 20 pp. $1.

Recommends and analyzes various types of insurance coverage for use in neighborhood centers in relation to employee benefits, property damage, liability, crime, and other coverage.

HIGH SCHOOL STUDENTS AND DRUGS: the report of a national seminar. Institute for Development of Educational Activities, Inc., Information and Services Division, Box 446, Melbourne, Fla. 32901. 1970. 20 pp. $1.

Discusses drug use and suggests educational programs for teenagers.

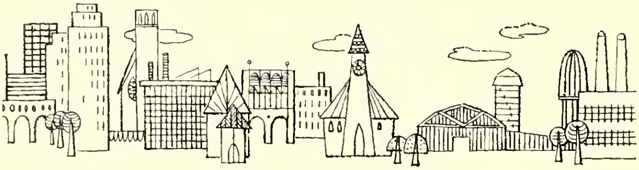
DRUGS ARE STILL NOT THE PROBLEM . . . BUT . . . Seymour S. Cohen. B'nai B'rith Youth Organization, 1640 Rhode Island Avenue, NW., Washington, D.C. 20036. 1970. 8 pp. 10 cents.

Suggests ways of reversing the current "fad" of drug use among teenagers.

A PARENTS' PROGRAM IN A SCHOOL FOR THE DEAF. Paul Rotter. The Lexington School for the Deaf Education Series, Book VI. Alexander Graham Bell Association for the Deaf, Inc., 1537 35th Street NW., Washington, D.C. 20007. 1969. 114 pp. $4.25.

Describes why and how parents are involved in the educational process in a school for the deaf.

HERE and THERE



Health services

Establishment of community, State, regional, and Federal child health advisory councils to coordinate the provision of health care for economically deprived children from birth to 12 years of age was recommended by participants in a 3-day conference held in Washington, D.C., in mid-September. Initiated and financed by the Office of Child Development and cosponsored by the Office of Education, the conference was designed to develop systems of continuous, comprehensive health services for children served by Parent and Child Centers, Head Start, Follow Through, and Title I of the Elementary and Secondary Education Act of 1965, which provides compensatory educational programs for deprived children. The 35 participants included public health physicians and educators, parents, evaluation specialists, and administrators of local, State, and Federal programs with health components.

Integration of health supervision and nutrition into a comprehensive program designed to promote total development of children from low-income families must be a national priority, the conference participants agreed. Speakers identified a number of deterrents to the provision of optimum health care for children, among them: inadequate manpower in professional and paraprofessional health services, especially in rural areas; inadequate financial support of health and nutrition programs; lack of a national commitment to health care for all children by government and private agencies; and lack of coordination of the four programs with which the conference was specifically concerned.

It was pointed out that only a few communities have all four of the programs. The Office of Child Development administers 36 Parent and Child Centers and 1,800 Head Start programs, and the Office of Education directs Title I programs in 16,400 school districts and 150 Follow Through programs.

At the opening session Richard L. Fairley, acting director of OE's Division of Compensatory Education, said that Title I serves more than 8 million educationally deprived children in a variety of educational, social, cultural, and health programs. He reported on proposals that would require that a portion of Title I funds in each program be used for comprehensive health services, including dental and mental health components, and announced grants totaling $2 million for pilot projects to develop models of community coordination of health programs for children. Edward Zigler, director of OCD, told the conference that Head Start has provided health care to more than 3 million children since 1965. He warned that the quality of health programs for children must not be "watered down" as a result of continuing budget limitations.

Panel and group discussions centered on problems of implementing child development services in Follow Through and Title I programs and ways to link the four programs with existing community health services and other federally supported health services. In rural areas where few such services exist and where physicians are often not available, alternate methods of health care for low-income children must be developed, one panelist asserted.

Panel members described comprehensive school health programs in Tacoma, Wash., Oakland, Calif., and Philadelphia, Pa., that include health education and referral of children for correction of medical problems. One participant reported that the United States is the only major western country without a national school dental health program. Another participant advocated that mental health programs be conducted in the schools, so that they can reach all the children in need of such services, instead of in community mental health clinics, which only reach one of every 14 seriously disturbed children.

Discussion groups reported agreement that parents should participate fully in planning and coordinating health care in local, State, and Federal programs.

The conference also recommended that—

- Health programs be child focused.
- Health programs be mandatory in Title I as well as in Parent and Child Centers, Head Start, and Follow Through, but requirements be as flexible as possible.
- Common evaluation and monitoring systems, procedures, standards, and goals be developed and adopted for the four programs.
- Coordination of health programs be improved at all levels.
- Content of health programs be modeled on Head Start services and be reinforced by drawing on the strengths of the other programs.

Drug use

The use of amphetamine drugs is now limited to three specific medical purposes, under an order issued by the Food and Drug Administration in August to prevent their abuse. In the past, amphetamines have been widely sold as stimulants and appetite suppressants, but the order permits their sale only for uncontrollable sleepiness (narcolepsy), hyperkinetic behavior disorders in children, and short-term treatment of obesity. In issuing the order, the FDA asked manufacturers to reduce their production and sales of amphetamines.

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The National Institute of Mental Health has recently established a National Clearinghouse for Drug Abuse Information. The clearinghouse refers scientific and technical questions about drugs to government and private agencies, stores and retrieves computerized data on drug programs, and distributes government publications and films to parents, students, teachers, law enforcement officers, community leaders, and others concerned with the drug problem.

Inquiries in any area of drug abuse may be sent to the National Clearinghouse on Drug Abuse Information, Box 1701, Washington, D.C. 20013. A 24-hour-a-day telephone service has been set up; the number with area code is 301–496–7171.

Nutrition

Pregnancy holds greatest risks for girls under 17 years of age who have not completed their own growth, for women in low-income families who have never had adequate diets, for women who restrict their weight gains to less than 15 pounds, and for women who have repeated pregnancies, according to a study by the Committee on Maternal Nutrition of the Food and Nutrition Board, National Research Council, released in July. Supported by the Maternal and Child Health Service (then in the Children's Bureau, but now in the Health Services and Mental Health Administration, HEW), the study of maternal nutrition and the course of pregnancy grew out of concern about the relatively high neonatal and infant mortality rates in the United States.

A long-term aim of public health activities should be to improve the nutritional status of women of childbearing age by beginning long before they reach that age, the committee advises. While it puts major emphasis on a good nutritional start early in life, it also recognizes that many other factors—genetic, biological, social, and psychological—are involved in a favorable outcome of pregnancy.

The committee raises the question of whether weight restriction contributes to the large number of low-birth-weight infants (those born weighing less than 5½ pounds) and the related high perinatal- and infant-mortality rates.

The study was conducted by working groups, which examined the relation of nutrition to fetal growth and development, pregnancy in adolescence, and toxemias of pregnancy. Among the groups' findings:

Fetal growth and development:

- An average gain in weight during pregnancy of 24 pounds is desirable, the acceptable range being from 20 to 25 pounds.
- Weight reduction program and severe caloric restrictions should not be undertaken during pregnancy, even for obese women, because of the possible adverse effects on the fetus' weight and development.
- Women who smoke during pregnancy are more likely to have low-birth-weight infants than comparable nonsmokers.

Pregnancy in adolescence:

- An increasing number of infants are being born to girls 17 years of age and younger.
- Disproportionately more low-birth-weight infants are born to mothers under 15 years of age.
- The mortality rate for infants of mothers under 15 years of age is 58.7 per thousand live births, compared with the U.S. average of 25.1 for all infants.
- Among pregnant girls under 17 years of age the incidence of iron-deficiency anemia, toxemia, premature births, and deaths of infants within 28 days after delivery is higher than among older pregnant women.

Toxemias of pregnancy:

- There is no evidence that caloric restriction, often recommended by physicians to reduce the chances of toxemia, has any effect on its incidence. Similarly, there is no evidence that excessive weight gain during pregnancy causes toxemia.
- The widespread practice of routinely restricting salt intake and at the same time prescribing diuretics is of doubtful value in preventing toxemia and is potentially dangerous.
- Emphasis should be placed on the value of a good diet during pregnancy, particularly for women entering pregnancy with poor nutritional status and poor dietary habits.

Among other recommendations, the committee urges that multidisciplinary research and training centers for studying the biology of human reproduction be established; that food programs for low-income families give special consideration to the physiological needs of infants, children, adolescents, and pregnant women; that community health services increase their nutrition services for mothers and children; that school curricula include basic nutrition information and the encouragement of good dietary habits; and that medical schools emphasize the role of nutrition in health.

The complete report, "Maternal Nutrition and the Course of Pregnancy," is available from the National Research Council, 2101 Constitution Avenue NW., Washington, D.C. 20418. (Price: $7.50) A summary report is available without charge from Maternal and Child Health Service, Room 12A–21, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852.

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Monosodium glutamate (MSG) should not be added to foods specifically designed for infants, concludes a committee of the National Academy of Sciences-National Research Council in a report of a study issued in August. While the committee reports that the risk of harm to infants from MSG is extremely small, it notes that the additive does not benefit infants in any way. The committee also reports that it found no evidence of hazard "from the reasonable use of MSG in foods for older children and adults, except for those who are individually sensitive to the substance."

The study was requested by FDA in January 1970 in the wake of questions about the safety of MSG in baby foods. U.S. manufacturers of baby food discontinued the use of MSG in their products in the fall of 1969.

Behavior modification

A system of rewarding emotionally disturbed children for academic progress and socially acceptable behavior in the classroom has proven effective in a pilot program now in its third year in the Great Falls, Mont., public school system. Conducted with a grant from the U.S. Office of Education under title III of the Elementary and Secondary Education Act, the program provides two educational adjustment classrooms for children whose emotional problems are so severe that they no longer can be retained in a regular classroom setting.

Children selected from the program have average or near average intelligence, but are achieving below grade level. The program begins with identification and recording of incidents of their specific modes of negative behavior during a 2-week period. A special curriculum is then devised for each child, based on his academic strengths and weaknesses. The child is rewarded for correct academic responses and appropriate social behavior by being given free time in the "high strength" area of the classroom, equipped with arts and crafts materials, games, toys, books, a phonograph, and a tape recorder. Problem behavior—hitting, spitting, kicking, "talking out" or yelling and screaming at the teacher, and "out of seat" movement—is ignored by the teacher and other students when it is used as an attention-getting device. If such behavior becomes dangerous to persons or property, the student loses free time he has earned.

The school nurse visits the home of each child enrolled in the special classes and helps the parents establish a program similar to the one used in the school. Four training groups were organized for parents of children in regular classes during the first 2 years. Additional groups are planned for the current school year.

At the end of 2 years, 16 of the 29 students in the adjustment classrooms were able to return to regular classes. The teachers considered the social behavior of all students to be within acceptable limits at that time. No student was then taking medication for control of behavior problems, although about 80 percent of the students had been on medication when they entered the program.

In 1969–70 a resource teacher was hired to support teachers in regular classes in planning and managing behavior of disturbed students. She consulted with more than 70 teachers in 27 schools, and worked closely with 42 students who remained with their classes. Ten training sessions were held for 154 teachers and principals.

William L. Findley, supervisor of special education in Great Falls, is director of the project and Ray Beck, psychologist, is program coordinator.

Child health

In 1970 a teenager in the United States is infected with venereal disease almost every minute of every day, according to the Public Health Service's Center for Disease Control in Atlanta, Ga. The Center has estimated that about 1,300 new cases of infectious venereal disease—gonorrhea, primary syphilis, and secondary syphilis—occur each day in the 15–19 age group and about 1,900 new cases occur in the 20–24 age group.

For gonorrhea, the rates among teenagers and young adults during the 1960's showed a sharp upward trend. For example, from 1965 to 1968, gonorrhea increased from 401 reported cases per 100,000 persons to 611 reported cases per 100,000 persons in the 15–19 age group and from 918 reported cases per 100,000 persons to 1,251 reported cases per 100,000 persons in the 20–24 age group. Public health officials believe that reports are made on only one out of every four treated cases of venereal disease.

For the 1968 calendar year, 5,804 cases of gonorrhea were reported among children 14 years of age or younger. Of the 111,829 cases of venereal disease reported in the 15–19 age group that year, 97 percent were gonorrhea.

The incidence of syphilis in all age groups is now increasing, after a gradual decline from 1966 to 1969. Provisional data for fiscal 1970 indicate an 8.5 percent increase in reported cases of primary and secondary syphilis; a breakdown of figures by age groups is not yet available.

Syphilis caused 15 infant deaths in 1967, a decrease of 10 from the previous year, the center reports. In 1968 a total of 327 cases of congenital syphilis was reported in infants between birth and 1 year of age, compared to 277 cases in 1969.

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By mid-September, more than 13 million doses of rubella vaccine had been given to children in public programs and between 2 and 3 million doses had been given by private physicians, under the nationwide Stop Rubella campaign launched by the Public Health Service's Center for Disease Control in June 1969. About half of the vaccine used in the United States to date has come from the Federal government, with the remainder from State and local resources. State and local health departments are conducting the active immunization programs.

Clinical reactions from the rubella vaccine are less common than from the regular measles vaccine, according to CDC officials. However, some transient joint pain and swelling have been reported among vaccinated children. The small joints of the hands and knees are most often affected, with the condition beginning 2 to 8 weeks after vaccination and lasting 1 to 8 days.

Many voluntary organizations are working with local health departments in the Stop Rubella campaign under the leadership of the National Center for Voluntary Action, 1735 Eye Street N.W., Washington D.C. 20006. Among them are labor, religious, veteran's, women's, youth, health, and fraternal organizations; chambers of commerce; service clubs; and associations of parents and teachers. In addition to helping with record keeping and other clinic operations, the volunteers are working on publicity, organizational activities, and fund-raising.

Infant development

A pilot infant project that enlists parents in promoting optimal development of very young children through a program of observation and selective intervention was started during the fall at the Dubnoff School for Educational Therapy in North Hollywood, Calif. The program is focused on the emerging personality of infants at least 6 months old, some of whom appear to be developing normally and some of whom exhibit behavior difficulties without apparent organic cause, such as apathy, restlessness, hyperactivity, lack of response to stimuli, poor eating and sleeping habits—indicating they are at high risk of developing emotional problems as they grow older.

The theoretical concept for the project—that intervention will help prevent deviant behavior or correct it before it becomes stabilized—stems from the work of Emmi Pikler of the National Methodological Institute for Infant Care and Education in Budapest, Hungary. The project's design was tried out in a prepilot program involving six infants and their mothers, at the Dubnoff School's Infant Center between June and December 1969 under the guidance of Madge Gerber, project director.

The infants and mothers spent 2 mornings each week at the center in an environment designed to facilitate spontaneous exploration and learning. Mrs. Gerber demonstrated methods of selective intervention that allow the child to reveal himself, to make his own choices, and to evolve his own style of mastery. After learning the techniques of accurate observation, each mother watched her own child's behavior through a one-way mirror when he was by himself, with other infants, and with other adults. All mothers participated in planned discussions with staff members and other mothers. The director visited each home from one to three times during the study period.

Extensive tests were performed before, during, and after the prepilot program. Followup studies of the infants in the prepilot program as well as in the pilot project will measure the long-range effects of changes on the quality of the infants' development, the mothers' attitudes, and the quality of interaction between the mother and infant.

Mental health

The Jewish Vocational Service of Chicago recently reported on a 3-year study of the progress of 76 emotionally disturbed adolescents in vocational rehabilitation programs integrated with the programs of child care agencies that were treating the adolescents and their families. Supported with a Federal grant from the Children's Bureau, the study was carried out from June 1964 to October 1967 under the direction of William Gellman, the agency's executive director.

While as a whole the adolescents did not show significant changes on measures of improvement, the data revealed the existence within the total group of two subgroups: a high performance group of young people who did profit from the program, and a low performance group of young people who declined in performance. The young people in the high performance group displayed better capacity for work before, during, and at the end of their vocational programs and seemed to have a capacity to recognize, take responsibility for, and learn from their own errors. In contrast, the young people in the low performance group seemed to be poorer workers in the beginning and to react to failure to perform to their own satisfaction with frustration, anger, and blame directed at the people about them.

The age of the participants on entering the program seemed to make no difference in their performance.

Because the young people involved in this study were emotionally disturbed, the staff was confronted with much moodiness, manipulation, and testing, according to Dr. Gellman. He found that the younger staff members seemed to bear up better under physical strain of the program, but that crises were handled best by staff members with professional training, regardless of age.

Indian youth

A reluctance of young Indians to enter the white man's world because of strong feelings of Indian identification was revealed in a demonstration project to explore the possibility of intercultural exchange between the students of an Indian boarding school and white families in the surrounding community, according to John D. Little, the project director. The project, called the Transitional Opportunities Project for Students (TOPS), was undertaken in August 1967 by the Lutheran Social Services of South Dakota, with support from the Children's Bureau, and was closed in June 1970 because of lack of participation.

The project's primary objective was to learn if young Indian students' process of accommodation to the dominant society would be aided by their association with white families.

In the beginning, 60 boys and girls from the sophomore class at the Bureau of Indian Affairs boarding school at Flandreau, S.Dak., were selected as an experimental group and 60 others as a control group. All had lived on reservations before coming to the school. Each TOPS student was to be invited by a host family for weekends and if possible to live with the family all or part of the summer. This was to give the student an opportunity to live and perhaps to work in an off-reservation community.

From its inception the project encountered many problems. Prejudice and fear among both Indian students and prospective host families hampered arrangements. Many of the students had severe social and emotional problems and so found it difficult to relate to any adult, particularly a white adult. Nearby communities were hostile toward Indians. Some host families were unrealistic in their expectations of the young people. Other obstacles were refusal of parents to grant permission for a young person to participate in the summer program; inability to find suitable host families; the scarcity of available jobs; and reluctance of students to carry through their plans.

Although 32 students had expressed interest in living with host families during the summer of 1968, only eight did so. However, largely through the efforts of a student coordinator, 24 students stayed with host families in the summer of 1969. Weekend visits during the school year were the most popular part of the project; 36 students participated in the 1968–69 school year.

Summer placements with local families were most successful for girls, for students who showed unusual motivation, and for students who had no acceptable alternative living arrangement, the project found. It also found that families that welcomed the students with warmth, but without pressure or intimacy, were the most successful.

Miscellaneous

An interim report for 1970, listing programs of group infant care, has been published recently by the Cyesis Programs Consortium, with support from the Children's Bureau. Persons with information about additional group infant care programs are asked to submit brief descriptions for the final report, to be published later. Copies of the interim report are available from the Cyesis Programs Consortium, Room 505, 1145 19th Street, N.W., Washington, D.C. 20036.

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Research Relating to Children, a publication issued periodically by the Clearinghouse for Research in Child Life, Children's Bureau, has been transferred to the ERIC Clearinghouse on Early Childhood Education at the University of Illinois. The publication contains abstracts of studies relating to children or their families in such areas as child growth and development, intelligence, personality, education, social adjustment, family life, mental retardation, and physical and emotional disorders as well as studies of service programs in the fields of child health, child welfare, and special education. Bulletin No. 1 covered research reported between December 1, 1948, and June 30, 1949; Bulletin No. 26—the final issue prepared by the Children's Bureau—covers research reported between January and May 1970. It will soon be off the press.

CHILDREN AND THE MASS MEDIA

The influence of television programs, comic strips, books, and other media of communication on children and ways to improve such products were considered during 2 days of hearings in Washington, D.C. in mid-September. The hearings, which comprised the second meeting of the Forum on Child Development and Mass Media of the White House Conference on Children, brought together about 100 people to listen to testimony from representatives of the mass media, child development specialists, and others who work with children or their materials.

The major questions considered were how to get the best "mix" between the ideas of the producers and creators of children's programs and literature and the knowledge of child development specialists; what artists and other creative persons need from the specialists; and what they would use.

The forum, one of 24 preparing material for the White House Conference on Children, is using the testimony from the hearings in compiling its report and recommendations for the Conference to be held in Washington Dec. 13–18. Fred Rogers, creator of the children's television program, "Mister Rogers' Neighborhood," is chairman of the 16-member forum; Morrie Turner, creator of the "We Pals" cartoon, is its vice chairman. Other members include representatives of various professional fields, the producers of educational materials for children, and concerned citizens.

Advice from the experts

A pediatrician, T. Berry Brazelton of Cambridge, Mass., maintained that after watching TV for an hour, the child is exhausted because he has been passively involved in life "out there" with its violent fantasies: "The child's ego structure is laid bare and he is forced to reorganize himself all over again." Dr. Brazelton praised the programs, "Mr. Rogers' Neighborhood" and "Sesame Street," for "demanding that the child be actively involved." He noted that the older a child gets, the easier it is for him to get "hooked" by TV, for he loses his power to "tune out" or "tune in" visual and auditory cues.

An optometrist, Bernard Mallinger of Pittsburgh, Pa., spoke of the importance of the perceptual development of the child in enabling him to sort out and deal with experiences intelligently. "From my point of view," said Dr. Mallinger, "the child is in school from day one of life. It is this school, his education by experience, that provides so much of the substructure of intellectual growth."

A psychoanalyst, Helen Ross of Washington, D.C., testified that some children find help in overcoming their difficulties from the warm positive attitudes in television programs. She added, however, that TV performers and scriptwriters ought to know something about children in different age periods, especially about their emotional growth.

Different viewpoints on the value of advice from child development experts were expressed by producers of programs and materials. One, Ezra Jack Keats, a writer of children's books, said he finds any rules and regulations inhibiting. Another, Carl Nater, president of the Walt Disney Educational Materials Co., said the film producer should accept what the experts say "if it is good." But then he posed a problem: Who determines who is an expert? And will today's expert be tomorrow's expert in a field so subject to "transitory techniques" and "widely varied opinions" as education?

Still another producer, Morton Schindel of Weston Woods Studios, maintained that the most valuable training in communicating with children is "to understand ourselves." What the field of communications for children needs, he said, are authors with "conceptual talent" and illustrators who have something to convey.

In regard to the content of children's TV programs, Chuck Jones, director of Children's Programs for the ABC network, advocated that each program have at least two of the following three components: (1) entertainment, (2) education, (3) stimulation. In the forthcoming TV show "Curiosity Shop," he said, children will be helped to perform feats that require more physical skill than just turning on the TV set.

One of the forum members, Joan Ganz Cooney, brought up the problem of how to reconcile differences in audiences. For parents of children from the lower socioeconomic groups who may need cognitive stimulation, the media might stress the importance of reading to children, she suggested, while for children from middle-class homes, who may be exposed to more "good conversation," the media should probably convey the message "relax and enjoy your children." Neil Hickey, New York bureau chief for *TV Guide*, suggested setting up a mechanism through which the TV stations could produce and exchange programs for children to reflect the rich variety in our country.

Evelyn Sarson, cofounder of Action for Children's Television, told of the organization's goal of having all commercials eliminated from children's programs and a "minimum of 14 hours of programs weekly" provided for children of different age groups.

Window to the world

An emphatic statement that TV could never be more than an auxiliary to the parent or the teacher in educating a child came from Bob Keeshan, Captain Kangaroo of the TV series, who could not be present at the hearing. The basic purpose of a good TV program for children, he said, is to serve the child as a window to the world around him. "It cannot teach the child to read, but only make him want to read."

Senator John Pastore, chairman of the Senate Subcommittee on Communications, and Dean Burch, chairman of the Federal Communications Commission, were the concluding speakers at the hearings. Both emphasized that the broadcaster is responsible for determining what goes over the air. Senator Pastore, however, pointed out that "parents, educators, producers, writers, social scientists, the FCC, and we in Congress can make our advice available" to the broadcasters.

At the conclusion of the hearing Chairman Rogers expressed the hope that a committee be established to continue looking at the problems, and that a permanent institute be set up to serve as a link between child development specialists and those in the mass media. Edward Zigler, director of the Office of Child Development, has offered the forum the services of OCD in following up on the latter suggestion.

Shirley Winston

IN THE JOURNALS

Questions about rubella

The New England Journal of Medicine for July 30, 1970, contains two articles and an editorial that raise some questions about the possibility of eradicating rubella—and so protecting the fetuses of pregnant women from being damaged by the virus—by inoculating children with an attenuated vaccine.

One article reports on an epidemic of rubella in four units of a children's institution 5 months after some of the children had been immunized with an attenuated virus vaccine. ("Clinical and Serologic Studies in an Outbreak of Rubella in a Vaccinated Population," by Te-Wen Chang, M.D., Suzanne DesRosiers, M.D., and Louis Weinstein, M.D.) It reports that while none of the vaccinated children showed clinical signs of the disease, serological tests showed that 50 percent of them had been infected with the wild virus, thus raising the question of whether vaccinated children might become unsuspected carriers.

The other article reports on a case of vaccine-strain rubella in a nonvaccinated child, which may have been contracted from a vaccinated member of her family. ("Controlled Family Study of Live, Attenuated Rubella-Virus Vaccine," by Lewis B. Lefkowitz, Jr., M.D., Robert R. Rafajko, Ph. D., Charles F. Federspiel, Ph. D., and Robert W. Quinn, M.D.) It raises the question of whether a pregnant woman could be infected by a vaccinated child and pass the infection on to the fetus.

In the editorial, John F. Enders, Ph. D., cites these and other research reports as suggesting that there are variations in the degree of immunity conferred by vaccination, that some vaccinated persons may become carriers of either the wild or attenuated strains of the virus, and that women vaccinated in childhood may eventually lose their immunity. While he suggests research on "more direct methods" of protecting unborn children, he advocates that doubts about the long-range effectiveness of the present nationwide rubella vaccination program "not for the present be allowed to interfere with its continuation."

Work potential in AFDC

Women receiving public assistance under the program of Aid to Families with Dependent Children (AFDC) who have a high school education or previous work experience and jobs skills have had to face just as many barriers to employment as those with less education and training, according to an analysis of data from employability studies reported in the July–August 1970 issue of *Welfare in Review*. ("How Employable are AFDC Women?" by Perry Levinson.)

Of the women studied, the author finds that 44.5 percent had a high employment potential in 1968 as defined on the basis of a high school education and past experience in skilled or white-collar jobs, a significant increase from the 25.3 percent in 1961. He points out that women in the program who were under 30 years of age and those who were living in urban areas were better educated and had better occupational skills than did the older women in the program and those living in rural areas.

According to the author, many conditions prevent women with high employment potential from applying for work. The barriers include children under 8 years of age (76.6 percent of the women with low employment potential and 81.7 percent of the women with high employment potential); poor availability of day care (51 percent, low potential, and 50.2 percent, high potential); poor general health (45.9 percent, low potential, and 37.6 percent, high potential); and low self-esteem (41.5 percent, low potential, and 33.2 percent, high potential). He reports that 37.5 percent of the high potential group and 29.5 percent of the low potential group had at least four barriers to employment.

As a byproduct of his study, the author finds that eligibility policies of cities and States in regard to AFDC act to exclude women with high employment potential.

Parental views on TV

Differences in both educational background and class—as defined by the father's occupation—make a difference in the way parents react to their children's use of television, the greatest difference being among fathers, according to two sociologists writing in the August 1970 issue of the quarterly, *Marriage and the Family*. ("Parental Perceptions of the Role of Television in Parent-Child Interaction," by Cora A. Martin, Ph. D., and Leonard Benson, Ph. D.) They are reporting on a study they made in 1966 of the television habits of 183 white families in Omaha, Nebr., who had children in the sixth grade. Individual interviews with the mothers and fathers were used to determine parental attitudes toward television habits, and the results were classified by social class (upper, middle, and "working") and the level of the parents' education.

The authors found that the attitudes and behavior of mothers toward television viewing by their children were similar across class and educational lines, although working-class mothers tended to make the strictest rules. Working-class fathers tended to be the most indifferent. Upper-class and professionally educated fathers discussed the content of television programs with their children more frequently than any other group, but the next most frequent group in using television as an educational aid for their children consisted of working-class mothers with less than a high school education.

Suburban state of mind

Richard Sennett, writing in the September 1970 issue of *Transaction*, presents an analysis of the consequences to family life of living in one-class communities where all inhabitants have approximately the same kinds of background, values, and income. ("The Brutality of Modern Families.") In his view, the outstanding characteristic of such family life is the intensity of family relations. This he describes as a "state of mind" in which family members "believe that the actions and feelings that transpire in the family are in fact a microcosm of the whole range of 'meaningful' actions and feelings in the world at large."

This style of living tends to reduce all family members to equality, consequently limiting the possibilities for sophistication and tolerance of its members as individuals, the author maintains. He points out that in such families conflict is viewed as bad, and that individuals feel very anxious and guilty if conflict does occur—for example, when differences arise from the normal maturing of the children.

Children in one-class communities—such as the modern suburbs—are denied the growth experiences that come from contact with really different people and ideas, the author maintains. The "ultimate good" in such areas, he says, is regarded as recreation involving the whole family.

He suggests that such views of life produce "passivity". When people explain proudly what they gave up for the sake of the children, they are willing to sanction repression of the poor, the different, so that there "need be no intrusions on the 'meaningful' circle of one's own life, the intimate relationships between Pop, Mom, and the kids."

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readers' exchange

GROB and VANDOREN: not for delinquents

I am somewhat concerned about an article that appeared in the May-June issue of CHILDREN entitled "Helping Houseparents Find and Use Their Creativity" by Harry E. Grob, Jr., and Eric E. VanDoren. My concern has been shared by several of our Board members.

Our concern is with the references to Chaddock Boys School as a private institution for juvenile delinquents. This is a misstatement of fact. I am sure that some of the parents of boys at Chaddock would be upset by such references.

Among the purposes of Chaddock Boys School as stated in our constitution are the following:

"To provide a Christian home, school and a wholesome environment for the care and education of boys where circumstances do not permit the boy remaining in his home and/or where the home is unsuitable for the boy's physical, mental, emotional, and spiritual growth and development.

"To provide a period of preparation or transition for boys to go into foster homes.

"To serve predelinquent emotionally disturbed and/or neglected boys who can better function in a group living environment than in a private home.

"To provide foster home placement for those boys who can best function in this type of environment."

Thus, Chaddock Boys School is a residential treatment-oriented agency serving predelinquent emotionally disturbed adolescent boys.

Charles W. Johnson
Executive Director
Chaddock Boys School
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PEARSON: A lode to be mined

John W. Pearson deals with a most difficult problem: what provisions should be made for delinquents who juvenile courts decide need supervision and special care? ("A Differential Use of Group Homes for Delinquent Boys," CHILDREN, July–August 1970.) They might be put on parole, sent to a training school, or placed in a foster home. The article recognizes the limitations in each of these plans, and it describes an experiment with research in the use of group homes (actual homes of the foster parents). The results are not encouraging.

Significant dimensions of these situations are not included. I hope that they will be when the data are fully analyzed. As the experience with "Cottage Six" makes vivid, delinquent boys (and others) develop a potent subculture as they live together. This needs attention. A related factor is group composition. Apparently the grouping described in this article was largely based on a classification scheme, and boys in the same category were put together in a group home. For example, boys classified as "Type II . . . manipulator or cultural conformist" were in one home. If these six boys were all manipulators, it raises serious questions about using this category as a basis for grouping. Unfortunately the article does not relate the group home parents' and parole agents' ratings of changes in the boys to the categories.

The ratings, done at 2-month intervals, seemed to show poor results when the young people were in the homes for more than 4 months, especially in the eighth month ratings. Mr. Pearson indicates that the average stay for all of the 39 boys in the group homes was 5.4 months. Was there a selective process at work so that only the most difficult boys remained in the homes for 8 months? When some boys left, were others assigned to the homes? If so, did the "old timers" become leaders?

Arrangements with four of the seven sets of foster parents had to be terminated because they were not performing satisfactorily. Under these conditions, did the group home approach have a fair test? It would help to have separate tabulations of the ratings of those foster parents who continued through the full period and those who did not.

The ratings were based on behavior in the home and probably whatever was known about behavior elsewhere. There is still the question of how the boys act beyond the purview of the staff, and how they will behave in the future.

This experiment involves many variables and other complexities. I hope, however, that Mr. Pearson and his colleagues will mine all the gold that is there.

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LEARNING TO TALK: speech, hearing, and language problems in the preschool child. HEW, PHS, National Institutes of Health, National Institute of Neurological Diseases and Stroke, Bethesda, Md. 20014. 1969. 48 pp. 45 cents.

Gives parents some guidelines to follow when they suspect that their child is troubled by one of the three communication disorders: speech, hearing, and anguage.

LEGAL BIBLIOGRAPHY FOR JUVENILE AND FAMILY COURTS: supplement 3. 1969. William H. Sheridan and Alice B. Freer. HEW, SRS, Office of Juvenile Delinquency and Youth Development. 1970. 36 pp. 45 cents.

This third annual supplement to a bibliography first issued in 1966 by the Children's Bureau lists selected references in 22 subject areas, among them adoption, child abuse, criminal law and procedures, custody, delinquency, domestic relations, due process for juveniles, family court and family law, illegitimacy, negligence, parental liability, probation services, and right to treatment.

A FEDERAL SOURCE BOOK: answers to the most frequently asked questions about drug abuse. Departments of Defense, HEW, Justice, and Labor and Office of Economic Opportunity. 1970. 32 pp. 25 cents.

Replies to questions about the abuse of such drugs as marijuana, hallucinogens, stimulants, sedatives, and other mind-affecting substances; and contains a glossary of users' terms.

ANNOTATED BIBLIOGRAPHY ON MATERNAL NUTRITION. Committee on Maternal Nutrition, Food and Nutrition Board, National Research Council and National Academy of Sciences. HEW, PHS, Health Services and Mental Health Administration, Maternal and Child Health Service. 1970. 199 pp. $1.50.

Includes selected materials published from 1958 through 1968 relating to research on maternal nutrition and the course of pregnancy.

KEY ISSUES IN INFANT MORTALITY—a report of a conference. Frank Falkner, M.D. HEW, PHS, National Institute of Child Health and Human Development. 1970. 84 pp. $1. Single copies free from Public Information Office, NICHD, Building 31, Room 2A-49, Bethesda, Md. 20014.

Reports on a meeting convened in April 1969 by NICHD to explore the medical and social aspects of infant mortality and discusses ways of decreasing deaths among infants in the United States and of assuring their intact survival.

BOYS IN FATHERLESS FAMILIES. Elizabeth Herzog and Cecelia E. Sudia. HEW, OCD, Children's Bureau. 1970. 120 pp. Single copies free from OCD.

Reviews and analyzes research concerned with the effects on boys of spending at least part of their childhood in homes without fathers and raises some questions about conclusions that relate the experience to juvenile delinquency, identity difficulties, and problems in intellectual and psychosocial functioning.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service.

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OFFICE OF CHILD DEVELOPMENT
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